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ALCOHOL AND THE ARMED FORCES

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public health service alcohol,drug abuse, and mental health administration

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ALCOHOL HEALTH AND RESEARCH WORLD

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ALCOHOL AND THE ARMED FORCES

James F. Holcomb

> The admissions to sick report charged to alcoholism and its effects numbered 1,110, the discharges 2, and the deaths 1; the admission rate was 47 (per 1,000), and the constant non-effective rate .52 per 1,000 of mean strength; 3.7 percent of all the admissions to sick report during the year, and 1.3 percent of all the time lost through sickness, were due to these causes.
>
> Excerpt from the *Report of the Surgeon General of the Army to the Secretary of War for the Fiscal Year ending June 30, 1887*

Alcohol and the problems it brings to the Armed Forces of the United States is not a phenomenon of the 20th century. The quotation above, taken from an 1887 report of the Army Surgeon General, applied to an army whose average strength, as calculated from medical reports, was reckoned at 23,572, excluding the Indian scouts. The alcohol-related admissions to sick report were only those cases serious enough in the eyes of the sufferer or his commander to require medical help.

"Armed service problems with alcohol have existed since the first soldier took up his weapon," according to Marc A. Schuckit, M.D., noted scholar on alcohol problems in the Armed Forces (1977). While most who have studied the problem agree that the extent and nature of problem drinking in the military closely parallels that in the civilian population, there are some conditions unique to the military. "Most evidence indicates that alcohol-related problems other than alcoholism occur with the greatest frequency between the ages of 18 and 24. . .precisely the ages when young people enter the military services," notes Major J. Killeen, USAF, of the Office of the Assistant Secretary of Defense (1979). "In fact, over one-half of the personnel on active duty in the armed services are below the age of 25 years."

Perhaps even more alarming was a 1974 report by the Institute for Social Research at the University of Michigan that, of high school seniors classified by a survey as heavy drinkers, 42 percent said they would probably apply for entry into the services, and an additional 43 percent said they definitely would apply for entry into the military.

Some observers have pointed to the possibility that the military environment is in some ways a contributor to the development of drinking problems. Retired Captain Joseph Pursch, founder of the respected Long Beach (California) Naval Medical Center alcoholism rehabilitation program, describes drinking practices in one segment of the services: "In naval aviation, we

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drink after a good flight, after a bad flight, and after a near midair collision. To celebrate our first solo flight, we traditionally present our instructor with a bottle of his favorite liquor. If we successfully bail out of a crippled airplane, we express our thanks to the lifesaving parachute rigger with a bottle of his preferred spirits. We drink when we get our wings, at a wetting-down party when we get promoted, to alleviate our depression when we get passed over, at formal dinings-in, change-of-command ceremonies, and chiefs' initiations; a night carrier landing can mean medicinal brandy. We 'hail-and-farewell' frequently. The first liquid that wets the bow of a newborn ship is champagne. In short, we drink from enlistment to retirement. . .from teenhood to old age."

Armed services officials have grown increasingly aware of the consequences of drinking problems among military men and women—and their families, and in the past 10 to 15 years, a number of measures have been initiated to prevent alcohol problems and to rehabilitate those persons with alcohol-related problems (see accompanying article). In 1887, the number of soldiers on sick report with an alcohol problem amounted to 47 per 1,000. In 1980, the number of soldiers who visited a doctor for an alcohol problem amounted to 23 per 1,000. It appears that progress is being made.

However, the Department of Defense (DoD) recognizes that assessment of progress in dealing with an area as complex as alcohol and drug problems requires information about a wide range of factors. For example, what about those drinkers, in many cases heavy drinkers, who feed their drinking habit for years without reporting to sick call for an alcohol problem? Common sense tells us that there are many more of these than the number whose names finally appear on the sick book.

It was to obtain a measure of these unknown drinkers as well as of the dependent and problem drinkers that the DoD entered into a contract in 1979 with Burt Associates, Inc., to administer an anonymous personnel survey to a representative portion of the military population worldwide. The objectives of the survey and subsequent analysis were:

- To determine the prevalence of drug and alcohol abuse within the military using categories of abuse defined in terms of physical, social, and work consequences and physical and psychological dependence
- To determine the nature of drug and alcohol abuse in the military in terms of demographic characteristics and behavioral factors
- To compare subpopulations at high risk for drug and alcohol problems within the military to similar subpopulations of civilians
- To assess the effects of drug and alcohol use on the servicemember's personal well-being and military job performance, based on self-reported consequences
- To determine the social climate associated with the use of drugs and alcohol and the servicemember's admitted reasons for using drugs and alcohol.

The analysis of the survey data was done in two steps. The primary analysis was done by the contractor to answer the questions raised by the objectives. Secondary analysis was then conducted in the DoD Office of Drug and Alcohol Abuse Prevention to answer questions that surfaced as a result of studying the analysis report and the available data.

Primary Analysis of Alcohol Use

This discussion of the initial analysis of the survey data proceeds sequentially from what would be considered "normal" to more "pathological" drinking behavior and finally to consequences of alcohol use. Although both drug and alcohol use were investigated in the survey, this article deals only with alcohol.

The primary analysis of the alcohol data dealt with the following issues: What is the prevalence among military personnel of drinking different types of alcoholic beverages—beer, wine, hard liquor? How frequently is each type of alcoholic beverage consumed? What quantity of each beverage is consumed on a "typical" drinking day? How frequently do military personnel engage in "heavy drinking," defined as consumption of eight or more drinks in a single day? What proportion of military personnel suffer from "adverse physiological effects" of alcohol? What proportion of military personnel are "alcohol dependent"? What proportion of military personnel suffer certain consequences of alcohol use? To what extent does alcohol use cause work impairment among military personnel?

Respondents were questioned in detail about their drinking behavior. Questions focused on the length of time since their last use of alcohol; whether they drank during the past 30 days; the frequency of drinking each type of alcoholic beverage during the past 30 days; the quantity of each beverage consumed on a typical drinking day during the past 30 days; and the frequency of consuming eight or more cans of beer, glasses of wine, or drinks of liquor during the past 12 months.

Table 1. Length of time since last use of alcohol (Percentage of population)*

Last use	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Within 1 month	83	80	86	86	82
1-3 months	6	6	6	5	6
4-6 months	2	2	2	2	2
7-12 months	1	1	1	1	2
More than 1 year	4	5	3	3	4
Never used alcohol	4	6	2	3	4

*Percents may not add to 100 owing to rounding.

Table 2. Population using alcohol during past 30 days (Percentage)

Pay grade	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Total	83	80	86	86	82
E1-E5	83	81	88	86	82
E6-E9	77	75	78	83	78
W1-W4	76	76	80	*	**
O1-O3	83	80	88	91	82
O4-O6	91	92	94	84	90

*Less than 30 respondents.
**Not applicable.

Prevalence of Alcohol Use. As shown in table 1, only 4 percent of the respondents said that they had never used alcohol, while another 4 percent reported that it had been more than 12 months since they had had a drink. Thus it appears that practically all servicemembers drink an alcoholic beverage at least occasionally.

Reported use of any alcohol at all during the preceding 30 days, shown in table 2, is defined as current use. In interpreting this table, appropriate consideration should be given to the fact that more consumption of *any* alcohol is obviously not of the same importance as is heavy drinking and having problems related to drinking, which are discussed later. The main point of these findings is that *most* military personnel drink at least occasionally: 83 percent of the respondents can be considered current users of alcoholic beverages.

In general, the greatest prevalence of drinking at least a small amount of alcohol was recorded for senior officers (pay grade O4-O6), followed by junior officers (O1-O3) and junior enlisted personnel (E1-E5), senior enlisted personnel (E6-E9), and warrant officers (W1-W4).

Frequency of Drinking During Past 30 Days. Table 3 shows that, for all respondents combined, beer was the most frequently consumed alcoholic beverage; it was drunk by 73 percent of all military personnel at least once within the past 30 days, and by about one-fourth (26 percent) at least three times a week. Hard liquor (including mixed drinks) was consumed by about one-half of the respondents (51 percent) within the 30 days preceding the survey, but only 8 percent reported they drank hard liquor as often as three times a week. Wine was the least frequently consumed beverage; only 35 percent of the military personnel reported they had drunk any wine during the past 30 days, and only 4 percent had done so as often as three times a week.

Variations in the frequency of drinking by pay grade are also of interest. Senior enlisted personnel generally reported drinking less frequently during the 30 days before the survey than did junior enlisted personnel. Warrant officers generally reported less frequent drinking than did enlisted personnel.

Junior officer respondents generally reported less frequent drinking of both beer and liquor dur-

ing the preceding 30 days than did enlisted personnel; however, their frequency of wine consumption was higher than that among senior enlisted personnel and was roughly equivalent to the frequency reported by junior enlisted personnel.

The senior officers group, as a whole, reported drinking beer as frequently as did junior officers. However, senior officers reported drinking wine and hard liquor more frequently than did any other pay grade group.

The data were analyzed to determine if drinking patterns varied by geographic area (comparing four categories—the continental United States, Europe, Pacific area, and other locations). The most consistent pattern was a higher frequencyof wine drinking in Europe, by all pay grade groups. However, relatively few junior enlisted personnel in any region drank wine as often as three times a week. Some differences in regional drinking frequency patterns did appear for the officer groups, but they are based on small sample sizes.

Quantity of Alcohol Consumed During a Typical Drinking Day. Obviously, the quantity of alcohol consumed during a single day or drinking occasion is more relevant to the development of drinking problems than is the number of days during which any drinking occurs, although both quantity and frequency need to be taken into account in determining dependence upon alcohol. The data on quantity consumed help to provide a preliminary indication of which beverages are associated with the heavier types of drinking.

As shown in table 4, beer was the alcoholic beverage consumed in greatest quantity by all military personnel, and within each of the four military services, beer was the beverage that was heavily consumed by the most respondents. On a typical drinking occasion during the 30 days preceding the survey, 29 percent of all military personnel reportedly drank four or more drinks of beer; a drink of beer is defined as one 12-ounce can, bottle, or glass. Eight percent of the respondents reportedly engaged in "heavy drinking" of beer, defined as the consumption of eight or more drinks on a typical drinking day during the past 30 days.

Heavy drinking of wine was rarely reported (by about only 1 percent of respondents). Heavy drinking of hard liquor, however, was reported nearly as often as heavy drinking of beer; 6 percent of all respondents reported they had consumed eight or more drinks of hard liquor on a typical drinking day during the past 30 days. The respondents who drank hard liquor in the past 30 days were asked to indicate the number of ounces of hard liquor in

Table 3. Frequency of alcohol use during past 30 days (Percentage of population)*

Type/Frequency of use	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Beer					
Every day	4	6	4	5	2
5-6 days a week	7	7	9	8	5
3-4 days a week	15	14	17	17	12
1-2 days a week	20	20	20	23	20
Less than once a week	27	25	27	25	30
Did not drink	27	28	22	22	31
Wine					
Every day	1	1	1	1	**
5-6 days a week	1	1	1	1	1
3-4 days a week	2	2	3	2	2
1-2 days a week	8	8	6	6	8
Less than once a week	23	20	24	20	28
Did not drink	65	68	66	71	60
Hard Liquor					
Every day	1	1	1	1	1
5-6 days a week	2	2	2	2	1
3-4 days a week	5	5	5	5	4
1-2 days a week	13	13	14	15	11
Less than once a week	31	28	32	29	33
Did not drink	49	51	45	49	50

*Percents may not add to 100 owing to rounding.
**Less than half of 1 percent.

their average drink. The answers ranged from 1 to 5 ounces; the average was 1.7 ounces.

Variations by pay grade group in the quantity of alcohol consumed on a typical drinking day also were examined. Heavy drinking was reported almost exclusively by enlisted personnel. Worldwide, 12 percent of E1s to E5s and 4 percent of E6s to E9s reported heavy drinking of beer. The comparable figures for wine were about 1 percent for both enlisted groups. Eight percent of E1s to E5s reported heavy drinking of hard liquor, compared with 3 percent of the E6s to E9s. About 1 percent or fewer of the officer and warrant officer groups reported heavy drinking of each type of beverage.

Because officers reported heavy drinking only rarely, the analysis of regional differences in drinking patterns focused on enlisted personnel. For junior enlisted personnel (E1 to E5), the highest rates of heavy drinking generally appear in the continental United States (CONUS) and Pacific regions, followed by Europe and other locations, although there are a few slight exceptions. The regional patterns are also varied for senior enlisted personnel (E6 to E9). However, the highest rates of heavy drinking appear in Europe.

Frequency of Heavy Drinking During Past 12 Months. The previous discussion addressed *typical* drinking during the past 30 days and focused particularly on heavy drinking. Examination of the *frequency* that a person engages in *heavy drinking* during the past 12 months is a preliminary step toward analyzing the physical, social, and work consequences of heavy drinking.

Twenty-one percent of all respondents worldwide reported they had engaged in heavy drinking of beer at least once a week, and 11 percent reported doing this at least 3 days a week during the 12 months preceding the survey (table 5). About 5 percent reported heavy drinking of wine at least once a week, and about 2 percent reported such consumption at least 3 days a week. Heavy drinking of liquor was reported at least 1 day a week by 11 percent and at least 3 days a week by 5 percent of all respondents.

Worldwide, comparison by pay grade group of heavy drinking during the past 12 months showed that heavy drinking was rarely reported by officers and warrant officers. Twenty-eight percent of E1s to E5s and about 10 percent of E6s to E9s reported heavy drinking of beer at least weekly; weekly or more frequent heavy drinking of wine was reported by 8 percent of the junior and approximately 1 percent of the senior enlisted personnel. Fourteen percent of the E1s to E5s and about 5 percent of the E6s to E9s reported heavy drinking of hard liquor at least weekly.

Table 4. Quantity consumed on a typical drinking day during past 30 days (Percentage of Population)*

Quantity	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Beer					
1 drink	12	12	11	9	14
2-3 drinks	32	31	30	31	33
4-7 drinks	21	20	25	28	17
8-11 drinks	5	5	7	7	3
12 or more drinks	3	3	5	4	1
Did not drink	26	28	22	21	30
Wine					
1 drink	10	9	9	8	12
2-3 drinks	19	18	18	15	23
4-7 drinks	5	4	6	5	5
8-11 drinks	**	**	**	**	**
12 or more drinks	1	1	1	1	1
Did not drink	65	67	65	71	59
Hard liquor					
1 drink	10	9	9	7	12
2-3 drinks	23	22	24	22	24
4-7 drinks	13	12	15	14	11
8-11 drinks	4	3	5	6	2
12 or more drinks	2	2	3	2	1
Did not drink	48	50	44	49	50

*Percents may not add to 100 owing to rounding.
**Less than half of 1 percent.

Table 5. Frequency of drinking eight or more cans, glasses or drinks in a single day during past 12 months (Percentage of population)*

Type/Frequency	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Beer					
Every day	1	1	1	2	**
5-6 days a week	3	4	4	4	2
3-4 days a week	7	7	9	10	4
1-2 days a week	10	10	11	12	7
1-3 days a month	14	13	17	17	11
Less than monthly	20	19	21	23	21
Never	45	45	37	32	55
Wine					
Every day	**	1	**	1	**
5-6 days a week	1	1	1	1	**
3-4 days a week	1	2	1	2	1
1-2 days a week	3	4	3	3	2
1-3 days a month	6	7	7	6	5
Less than monthly	18	17	21	18	18
Never	70	69	67	70	74
Hard liquor					
Every day	1	1	1	1	**
5-6 days a week	1	1	1	1	1
3-4 days a week	3	3	4	5	2
1-2 days a week	6	7	8	6	4
1-3 days a month	11	10	13	12	9
Less than monthly	23	21	26	25	21
Never	56	57	48	50	63

*Percents may not add to 100 owing to rounding.
**Less than half of 1 percent.

Regional differences in heavy drinking patterns among E1s to E5s for all services combined are not large for any of the three beverage categories. The regional patterns are very similar to those identified in the discussion of frequent drinking. Slightly higher rates of heavy drinking of beer and hard liquor were reported by junior enlisted personnel in CONUS and the Pacific regions, followed by Europe. However, heavy drinking of wine was most prevalent in Europe, most likely reflecting the greater popularity of this beverage there. The number of respondents included in the category of other locations was too small to warrant regional comparisons.

Regional differences among senior enlisted personnel were not significant, and because officers rarely reported heavy drinking, no regional patterns can be identified for this group.

Adverse Physiological Effects of Alcohol. There is compelling evidence that a person consuming an average of 5 ounces of ethanol daily during a 12-month period is engaged in "chronic excessive alcohol consumption" and is at high risk of developing severe medical problems, such as cirrhotic or precirrhotic conditions. Consistent with this criterion, employed in the 1977 Rand survey of Air Force personnel (Polich and Orris 1979), persons reporting such levels of consumption are presumed to be adversely affected.[1] This is not meant to imply that consumption at lesser levels is safe; but 5 ounces a day for a year seems to be a sufficiently high level and duration so that few experts would disagree that adverse physical effects could be expected to occur in most cases.

Average daily ethanol consumption for each respondent was computed in ounces by combining the quantity of beer, wine, and hard liquor reportedly consumed on both typical and atypical drinking days. The majority of military personnel consumed an average of less than 0.6 ounces per day during the 12 months preceding the survey. This is roughly equivalent to one drink a day of either beer, wine, or hard liquor. One 12-ounce drink of beer contains about 0.48 ounce of ethanol; one 4-ounce glass of wine contains about 0.48 ounce of ethanol; and one drink of hard liquor contains about 0.7 ounce of ethanol (based on respondents' estimates that their average drink contained 1.7 ounces of hard liquor).

Upon further analysis, it was found that E1s to E5s

[1]The Department of Defense specified that this definition be used in this survey.

are, by far, the group with the highest proportion of personnel at risk (10.9 percent consuming 5 or more ounces of ethanol each day), followed by E6s to E9s (3.1 percent), 01s to 03s (0.7 percent), 04s to 06s (0.6 percent), and W1s to W4s (0.2 percent).

Alcohol Dependence. For the purpose of this analysis, a person was categorized as "alcohol dependent" if, during at least 48 of the 52 weeks in the preceding 12-month period, he or she experienced one or more of the following symptoms: tremors or shakes; morning drinking; impaired control; or blackouts.[2] The descriptions of these symptoms provided to respondents in the survey were as follows:

- Tremors (shakes)—"I had the 'shakes' because of drinking."
- Morning drinking—"I took a drink the first thing when I got up in the morning."
- Impaired control—"I could not stop drinking before becoming drunk."
- Blackouts—"I awakened the next day unable to remember what I had done while drinking the day before."

Respondents were asked to indicate how frequently each of the above symptoms had occurred. A score was computed on the alcohol dependence scale indicating the number of weeks at least one symptom had occurred during the past 12 months.

Table 6 shows that, worldwide, 7 percent of all military personnel were categorized as alcohol dependent during the 12 months preceding the survey and that alcohol dependency occurred most often among junior (10 percent) and senior enlisted personnel (3 percent). Alcohol dependency was rare among warrant officers and commissioned officers (1 percent or less for each group). This pattern by pay grade holds for the total population in the CONUS, Europe, and Pacific regions. The somewhat different pattern shown for other locations should be interpreted cautiously because of the small sample sizes, as should the rates for officers.

These patterns of alcohol dependence are quite consistent with the rates of heavy drinking described previously. This is, of course, to be expected because of the substantial correlation between heavy drinking and alcohol dependency.

Consequences of Alcohol Use. The respondents were asked to indicate whether certain consequences had occurred *because of their use of alcohol* during the preceding 12 months. Table 7 depicts the percentage of respondents who reported experiencing two general consequences of alcohol use during the preceding 12 months. It shows that 20 percent of all respondents reported having been "drunk without planning to" and 11 percent indicated they were "drunk more than 1 day at a time" at least once during the preceding 12 months. Twenty-three percent indicated they had suffered at least one of these consequences during that period.

Turning now to more specific consequences of alcohol use, table 8 depicts the percentages of respondents who reported that 1 of 15 physical, social, or work consequences of alcohol use had occurred during the preceding 12 months. It is believed that this set of consequences is a significant indication of hard core alcohol problems. There was considerable overlap in responses among the 15 specific consequences. For example, a person who received judicial punishment because of alcohol use might also have failed to get promoted. The total figures in table 8, reflecting unduplicated counts, show that 11 percent of all respondents reported suffering at least one consequence during the preceding 12 months.

The proportions of respondents reporting these consequences vary considerably by pay grade group. Respondents reporting they suffered consequences were most often E1s to E5s, followed by E6s to E9s, 01s to 03s, 04s to 06s, and W1s to W4s.

For all pay grade groups, the consequence most frequently reported was "became drunk without planning to," and the next most frequently reported was "drunk more than 1 day at a time." The latter consequence was rarely reported by officers—2 percent of 01s to 03s and 0.5 percent of 04s to 06s—but frequently reported by E1s to E5s (15 percent) and occasionally by E6s to E9s (4 percent).

Work Impairment Because of Alcohol Use. Table 9 shows the percentages of all military personnel who indicated they had suffered work impairment because of alcohol use during the preceding 12 months. "Lowered performance" was reported most commonly (22 percent), followed by "late for work or left early" (13 percent), "drunk/high while working" (11 percent), and "did not come to work" (5 percent). There is considerable overlap among the four categories. An unduplicated count shows that 27 percent of respondents reported suffering at least one consequence.

Examination of variations in reported work impairment by pay grade group show that E1s to E5s most often report this consequence, followed by E6s to E9s, 01s to 03s, 04s to 06s, and W1s to W4s. This type of work impairment most frequently reported by all pay grade groups was "lowered performance" and the median number of days this occurred was 2 to 3. These patterns are similar to

[2]The Department of Defense specified that this definition, used in a 1977 survey of Air Force personnel conducted by the Rand Corporation, was to be employed in this survey.

Table 6. Alcohol dependence* during past 12 months (Percentage of population)

Region/Pay grade	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
CONUS					
Total	7	8	10	11	4
E1-E5	10	11	13	14	5
E6-E9	4	4	5	4	2
O1-O3	1	1	****	3	0
O4-O6	****	0	0	1	1
Europe					
Total	6	8	5	**	3
E1-E5	9	11	7	**	4
E6-E9	1	2	1	**	1
O1-O3	****	0	1	**	0
O4-O6	1	***	3	**	0
Pacific					
Total	7	5	7	11	6
E1-E5	10	8	12	13	7
E6-E9	3	4	3	2	4
O1-O3	3	2	1	***	1
O4-O6	0	0	***	0	2
Other locations					
Total	4	5	4	**	4
E1-E5	5	6	4	**	6
E6-E9	3	3	3	**	3
O1-O3	0	***	***	**	***
O4-O6	4	***	***	**	***
Worldwide					
Total	7	8	9	11	4
E1-E5	10	11	12	14	5
E6-E9	3	3	5	4	2
W1-W4	****	0	0	***	**
O1-O3	1	1	****	5	****
O4-O6	****	0	1	1	1

*A person is defined as "alcohol dependent" who, during the preceding 12-month period, experienced one or more of the following symptoms during at least 48 weeks: (1) tremors (shakes), (2) morning drinking, (3) impaired control, and (4) blackouts.
**Not applicable.
***Less than 30 respondents.
****Less than half of 1 percent.

those discussed previously for the consequences of alcohol use.

Comparison of Alcohol Use Between Military Personnel and Civilians. The heaviest alcohol use in both military and civilian populations is reported by persons 18 through 25 years of age. To compare this high risk subpopulation in the military with civilians, the data from this DoD survey have been standardized with respect to the variables that are most closely correlated with nonmedical drug use: sex, age, marital status, and education. This provides comparative prevalence rates that are not biased by the differences in occurrence of these characteristics in the two populations.

The standardized DoD data has been compared with data on similar civilian respondents collected in the National Survey on Drug Abuse conducted by the National Institute on Drug Abuse about a year earlier than the survey of military personnel. The comparability of data is limited because the time periods differ. Further, the civilian survey, like all household surveys, excluded persons living in dormitories and some other group quarters and persons with no fixed address—subgroups that may be characterized by higher prevalence rates than persons living in households (Fishburne et al. 1980).

Given these limitations, table 10 shows that current and annual use of alcohol among military personnel aged 18 through 25 is slightly higher than that of comparable civilians.

Secondary Analysis

After review of the initial survey report, a number of questions arose that had not been foreseen

Table 7. General consequences of alcohol use during past 12 months (Percentage of population)

Pay grade/Consequence	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Total population					
Became drunk without planning to	20	16	25	23	18
Drunk more than one day at a time	11	10	16	16	6
At least one consequence	23	19	31	29	20
E1-E5					
Became drunk without planning to	22	18	27	24	20
Drunk more than one day at a time	15	13	22	20	9
At least one consequence	27	22	35	32	23
E6-E9					
Became drunk without planning to	17	12	23	20	14
Drunk more than one day at a time	4	4	7	4	2
At least one consequence	17	13	24	21	15
W1-W4					
Became drunk without planning to	9	3	18	**	*
Drunk more than one day at a time	***	0	1	**	*
At least one consequence	9	3	18	**	*
O1-O3					
Became drunk without planning to	16	13	24	15	12
Drunk more than one day at a time	2	3	1	4	***
At least one consequence	16	15	23	16	12
O4-O6					
Became drunk without planning to	12	7	12	21	14
Drunk more than one day at a time	***	0	*	1	1
At least one consequence	12	7	12	21	15

*Not applicable.
**Less than 30 respondents.
***Less than half of 1 percent.

Table 8. Consequences of alcohol use during past 12 months (Percentage of population)

Consequence	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Illness kept from duty 1 week or longer	2	2	2	2	1
Did not get promoted	2	2	1	3	1
Got lower score on efficiency or performance report	2	2	3	4	1
Received judicial or article 15 punishment	2	3	2	3	1
Arrested for driving after drinking	3	3	3	5	2
Arrested for nondriving drinking incident	2	3	3	4	1
Incarcerated due to drinking	3	2	4	5	1
Hurt in accident connected with drinking	2	2	4	4	1
Drinking caused accident where others hurt or property damaged	2	2	3	3	1
Spouse threatened to leave	2	2	2	2	1
Hit spouse or children	1	1	1	2	1
Spouse left	1	1	**	1	**
Entered rehabilitation or treatment program	2	2	2	2	1
Attended training or education program	2	2	2	3	1
Detoxified	1	1	1	1	**
Total reporting any consequence*	11	11	14	17	6

*Percentage of population reporting at least one of the consequences during the past 12 months.
**Less than half of 1 percent.

Table 9. Work impairment due to alcohol use during past 12 months (Percentage of population)*

Impairment/Number of days reported	Total DoD	Service			
		Army	Navy	Marine Corps	Air Force
Lowered performance					
0	78	81	70	71	83
1	5	5	6	7	5
2-3	7	5	10	9	6
4-11	6	5	8	8	4
12-39	2	2	4	3	1
40 or more	2	2	3	2	1
Late for work/Left early					
0	87	87	83	84	90
1	4	4	4	4	4
2-3	4	4	6	6	3
4-11	3	2	4	3	2
12-39	1	1	1	1	**
40 or more	1	2	2	2	**
Did not come to work					
0	95	94	95	95	98
1	1	1	2	2	1
2-3	1	1	2	1	1
4-11	1	1	1	1	**
12-39	*	*	*	*	**
40 or more	1	2	1	1	**
Drunk/High while working					
0	89	89	84	85	94
1	2	2	3	3	2
2-3	3	3	4	4	2
4-11	3	2	4	3	1
12-39	1	1	2	2	**
40 or more	2	3	3	3	**
Total reporting any impairment***	27	24	35	34	20

*Percents may not add to 100 owing to rounding.
**Less than half of 1 percent.
***Percentage of population reporting any impairment at least once during past 12 months.

Table 10. Prevalence of alcohol use among military personnel and comparable civilians (Percentage of 18- to 25-year-old population)

Use	Military (n = 8,224)	Civilian* (n = 2,022)
In past 30 days	84	82
In past 12 months	93	90

*Data are standardized with respect to sex, age, marital status and education, and is based on special tabulations from the 1979 National Survey on Drug Abuse conducted by NIDA.

when the original list of objectives was prepared, but were answerable with the available data. A secondary analysis was conducted by the DoD Office of Drug and Alcohol Abuse Prevention to answer questions bearing on the education and rehabilitation policies of the DoD. The following issues were addressed: military effectiveness and substance use; reasons for using and not using drugs or alcohol; medical treatment required by military personnel for an alcohol or drug problem; work consequences for those who use cannabis; family members who need help; and substance use by standardized service populations. This is a far from exhaustive list of available topics to be researched from the survey data, but represents only those of priority to the Office of Drug and Alcohol Abuse Prevention.

As with the primary analysis, the secondary analysis is based on data about both drug and alcohol use. However, in many instances the secondary analysis is interwoven with discussions of both drugs and alcohol, each dependent upon the other. Therefore, the following discussion in

some cases may touch on both drug and alcohol use.

Military Effectiveness and Substance Use. Impairment of military effectiveness for any reason is a problem that has serious consequences for all military services. It affects mission accomplishment, man-days lost, safety, and morale. For the purposes of this analysis, any event that adversely affected an individual's work was assumed to negatively impact military effectiveness. Four categories of impairment (table 9) were reported by survey respondents.

The number of times that the adverse consequences reportedly occurred during the 12 months preceding the survey was recorded. Categories of impairment were developed from the sum of reported occurrences for each of the types of impairment (lowered performance, late for work/left early, did not come to work, and drunk/high while working). A report of no occurrence during the past 12 months obviously denotes no impairment of military effectiveness. A sum of 1 to 7 occurrences denotes the least impairment of effectiveness, 8 to 30 occurrences characterize the next moderately impaired category, and 31 or more occurrences denote the most impaired category.

Data on levels of drug and alcohol use for those in each of these categories also were compared. The "level of use" definitions are somewhat complicated. Since a large percentage of military personnel use alcohol, the nonuser or occasional alcohol user was defferentiated from the heavy or dependent alcohol user. In addition to the two alcohol use levels, several categories of drug use were also developed. All use categories are based on current use, that is, any reported use in the 30 days preceding the survey; the categories are mutually exclusive.

Table 11 provides a relative look at military effectiveness impairment across drug use levels with alcohol use held constant, and vice versa. The categories must be read in relation to their row and column locations. For example, of military personnel who are nonusers or occasional users of alcohol and who do not use drugs, 90.9 percent reported no military effectiveness impairment during the past 12 months.

The trend for both the nonuser or occasional alcohol user group and the heavy or dependent alcohol user group shows an increase within each occurrence grouping as the drug use moves from occasional cannabis use to weekly other drug use. There is also a significant increase in the severity of impairment for the heavy or dependent alcohol user over that of the nonuser or occasional alcohol user across the drug categories. The data support the hypothesis that impairment is affected by alcohol and drug use and increases as use of alcohol and drugs increases.

Reasons for Not Using Alcohol. The survey instrument contained 10 frequently given reasons for not using alcohol. Responses from all military personnel who said that they did not drink and who chose one or more of the reasons were examined. Only about 4 percent of the respondents reported they never used alcohol, 4 percent said they had not used alcohol for more than 1 year, and an additional 9 percent said they had not used alcohol within 1 to 12 months before the survey. Thus, a small group of respondents, about 17 percent, formed the response group. As table 12 shows, the most important reason given by respondents in all services for nonuse of alcohol was fear for health, followed by interference with work or other activities, no desire for effects, too costly, tried but not interested, parents or relatives disapprove, against religion, had a bad experience,

Table 11. Military effectiveness impairment categories compared with substance use levels (Percentage of population)

Alcohol use level	Occurrences of impairment in last 12 months*	Non-drug user	Occasional Cannabis user	Weekly Cannabis user	Occasional Other drug user	Weekly other drug user
Nonuser or occasional alcohol user	0	90.9	78.1	53.2	40.2	32.7
	1-7	6.3	15.4	16.7	18.4	20.0
	8-30	1.7	5.2	14.0	13.5	15.3
	31+	1.1	1.3	16.1	27.9	32.0
Heavy or dependent alcohol user	0	77.3	59.7	44.2	29.6	21.2
	1-7	12.7	18.6	16.5	16.8	11.6
	8-30	6.6	15.0	15.7	20.1	16.0
	31+	3.4	6.6	23.6	33.4	51.2

*Four categories of work impairment are listed in table 9.

and friends disapprove. The least important reason was an existing medical or health restriction.

A comparison among the services shows no significant difference in importance assigned to each reason. The only differences come in the rank ordering, and even these are not significantly different from the total DoD ordering.

Reasons for Using Alcohol. The survey instrument contained 15 frequently given reasons for using alcohol. Alcohol users—those respondents who reported alcohol use during the preceding 12 months and who chose one or more reason for drinking—were categorized according to level of alcohol use, and the reasons for alcohol use were examined for each level. An occasional drinker is defined as someone who reported alcohol use at least once during the past 12 months but who does not qualify as a heavy or dependent drinker. The heavy drinker category includes the person who reported having eight or more drinks in a day at least once a week during the preceding 12 months. The dependent drinker reported at least one of the following symptoms during 48 weeks of the year preceding the survey: awakened the next day unable to remember what had happened while drinking the day before; took a drink the first thing in the morning; couldn't stop drinking before becoming drunk; and experienced "shakes" because of drinking.

The only individuals considered in this analysis were nonusers of drugs, to avoid confounding reasons for drinking with reasons for using drugs. It is interesting to look at the reasons that are most important at the different levels of alcohol use, shown in table 12. The dependent drinkers marked their top five reasons as relaxation, to unwind, boredom, bad mood, and depression. All of these reasons reflect an internal need to drink. The heavy drinkers do not differ greatly from the dependent drinkers in their top five reasons, also reflecting primarily internal needs. The occasional drinkers chose relaxation, to be friendly or social, to unwind, depression, and lots of parties. Note the increase in the importance of external social forces.

Military Personnel Requiring Medical Treatment for an Alcohol or Drug Problem. Responses from all of the surveyed personnel who reported some medical involvement for an alcohol or drug problem at least once during the 12 months before the survey were analyzed, based on six specific responses on the survey instrument.

Table 13 shows the percentages of surveyed personnel who responded that they needed medical treatment for an alcohol or drug problem at least once during the past 12 months. It is of interest that the reported medical treatment needs are less for drug problems than for alcohol problems. Overall, it is estimated that at least 1.9 percent of all military personnel need medical treatment for an alcohol or drug problem during a year. This represents about 39,000 service members.

Consequences for Those Who Use Cannabis With Correlations to Their Alcohol Use. Specific negative consequences attributed to cannabis use were examined and comparisons were made between the occasional cannabis user and the heavy cannabis user. Those classified as occasional cannabis users had indicated at least one use during the past 12 months. Those classified as heavy cannabis users reported at least weekly use. The only respondents considered in this analysis are those who use cannabis alone or with alcohol, but no other drugs.

Table 12. Reasons for drinking by level of use (Percent of alcohol users who do not use other drugs)

Reasons*	Aggregate	Occasional Drinkers	Heavy Drinkers	Dependent Drinkers
To relax	50.4	46.9	66.7	82.2
To be friendly or social	38.2	37.2	42.0	47.7
To unwind from job	21.2	17.7	33.1	62.2
Depression	16.6	13.0	29.4	56.7
Boredom	16.3	11.8	34.0	58.3
Bad mood	15.4	11.5	29.9	57.5
Lots of parties	14.8	12.8	22.4	37.0
Peer pressure	12.7	12.2	14.3	21.1
Depressing living quarters	11.8	8.5	23.5	48.2
To forget worries	10.6	7.4	23.3	45.8
Lonesome	9.9	7.5	18.0	42.4
Only recreation available	8.7	6.0	17.8	38.0
Low price	7.8	6.2	15.4	20.2
Many happy hours	6.2	4.8	12.7	16.7
Increase self-confidence	6.0	4.3	12.1	26.9

*Percentage of those listed for each reason represent respondents who classified the reason as "fairly" or "very" important.

Table 13. Military personnel requiring medical treatment for a drug or alcohol problem (Percentage of total population)

	Total DoD	Army	Navy	Marine Corps	Air Force
Illness of a week or longer connected with drinking	1.7	2.4	1.6	2.1	0.8
Illness of a week or longer connected with drug use	0.9	1.6	0.7	1.0	0.2
Hospitalized in connection with drinking	1.4	1.9	1.3	1.6	0.6
Hospitalized in connection with drug use	1.0	1.4	0.6	1.0	0.3
Visited doctor in connection with drinking problem	1.9	2.3	2.0	2.1	0.9
Visited doctor in connection with drug problem	1.0	1.4	1.1	1.1	0.4

The survey asked about adverse consequences resulting from drinking, from using drugs, and for reasons other than drinking or drug use. Responses regarding several types of consequences relating to cannabis use were grouped together and examined for both the occasional cannabis user and the heavy cannabis user. Table 14 shows the percentages of those reporting 13 types of consequences for three groups of cannabis users: those who use cannabis and may or may not use alcohol; those who use cannabis and are also nonusers or occasional alcohol users; and those who use cannabis and are also dependent alcohol users. For example, 7.8 percent of the occasional cannabis users who may or may not also use alcohol reported a 1-week illness during the past year. The measure of impaired military effectiveness was examined only at the seriously impaired level. The underlined percentages are estimated based on such a small number that the precision of the estimate is not as high as required. They are estimates and should be treated as such.

There are no significant differences in reports of negative consequence by the occasional and heavy cannabis user except for three pairings, denoted with an asterisk in table 15. While there appears to be some tendency for heavy cannabis users to experience more adverse consequences on some measures, firm conclusions cannot be drawn because of the small sample sizes for most of the categories. However, it can be seen that the consequences reported most frequently by both occasional and heavy cannabis users were adverse effects on promotion, an adverse efficiency report, or punishment under the Uniform Code of Military Justice. Further, impaired military effectiveness of 8 or more days in a year occurred more frequently among heavy cannabis users than among occasional cannabis users. The difference was significant for all except those who were also heavy or dependent alcohol users, suggesting a possible confounding of cannabis use with alcohol use.

Family Members Who Need Help. To develop an estimate of the percentage of servicemembers who believe their family members need help for a drug or alcohol problem, data for those who responded that they were presently married were analyzed. While this may not include all who have family members, it is thought to identify most.

Three percent of the married respondents stated that they did not know if their family members needed help. While the circumstances of those servicemembers cannot be ascertained, it may be that the servicemember is physically removed from family members while on assignment, is legally separated or divorced, or truly does not recognize that a drug or alcohol problem exists.

Of the servicemembers considered in this analysis, only 2.2 percent reported that they had a family member who needed help for a drug or alcohol problem. Although this is a small percentage of the total family member population, it represents a large number of dependents. While the exact numbers involved cannot be determined because the servicemembers were not queried on the number of their family members, it is estimated to be in excess of the numbers at present being treated in DoD programs. Of course, some may enter civilian rather than military treatment programs; however, it is suspected that many never seek help.

Substance Abuse for Standardized Military Service Population. The demographic profiles of the military service population are very different. The average age of enlisted personnel within the Navy and Army is 25; in the Marine Corps the

Table 14. Consequences for cannabis users (Percentages of those who use cannabis and do not use other drugs)

	Regardless of alcohol use*		Nonuse or occasional alcohol use		Heavy or dependent alcohol use	
	Occasional Cannabis user	Heavy Cannabis user	Occasional Cannabis user	Heavy Cannabis user	Occasional Cannabis user	Heavy Cannabis user
1-week illness during past year at least once	7.8	8.4	6.8	7.8	10.1	8.1
Adverse promotion effect	13.4	13.5	13.1	11.3	13.8	16.9
Adverse efficiency effect	9.9	12.3	9.3	9.3	11.8	16.8
Nonjudicial punishment	7.7	11.4	5.9	8.5	11.2	15.1
Adverse promotion, efficiency, or art. 15	20.8	24.4	20.2	18.9	***22.4	32.1
Driving arrest	4.8	9.0	2.9	4.1	9.4	15.5
Nondriving arrest	6.2	6.8	4.3	5.6	10.0	8.2
Any arrests	9.6	12.8	6.6	8.7	16.6	18.4
Jailed	4.5	6.1	2.9	3.8	8.3	9.4
Injured in accident	8.6	8.7	7.4	10.1	11.8	5.7
Injury or property damage to others	6.6	5.6	5.8	4.5	8.8	7.3
Caused or involved in accident	12.6	12.0	11.1	12.1	17.0	11.9
Military effectiveness impaired 8 or more days	***9.4	21.0	***6.4	19.2	16.7	23.9

*May or may not use alcohol.
**Underlined percentages are calculated from extremely small samples, and are estimates.
***Denotes significant difference between the two columns.

average age is 23; and the average Air Force member is 26.[3] High school graduates constitute 87.9 percent of the Army enlisted, 84.9 percent of the Navy enlisted, 82.2 percent of the Marine Corps enlisted, and 98.7 percent of the Air Force enlisted population.[4] Ninety-one and two-tenths percent of the Army enlisted force are male, while 93.9 percent of the Navy enlisted, 96.5 percent of the Marine Corps enlisted, and 89.1 percent of the Air Force enlisted are also male.[5] Bachelors make up 45.2 percent of the Army enlisted, 58.2 percent of the Navy enlisted, 68.9 percent of the Marine Corps enlisted, and 40.1 percent of the Air Force enlisted population.

It often has been hypothesized that the different service profiles are responsible for a great deal of the differences among drug use and drinking prevalence rates. To test this hypothesis, a standardizing adjustment was made to compensate for profile differences. By standardizing the service populations, the relative ranking of substance use among the services can be determined. The service populations were standardized with regard to age, sex, marital status, educational level, and a stability factor based on survey-reported demographics rather than on total population demographics. The stability factor was based on the survey question about deployment at sea or in the field. Since the major category of substance abusers or high risk servicemembers are the enlisted personnel with less than 48 months of service, only this subpopulation was standardized and the survey data analyzed.

Table 15 displays the percentages of this standardized subgroup of respondents who reported use of alcohol, cannabis, and any drug except cannabis; substance use categories are not mutually exclusive, as the alcohol user may also use drugs.

For this standardized subpopulation, there is significantly less reported alcohol use for the Army than for the other services. There is no significant difference in percentages of alcohol use among Air Force and Marine Corps personnel. Navy personnel reported a significantly higher percentage of alcohol use tan the other services.

Air Force personnel reported the lowest percentage of cannabis use. Army personnel reported the next lowest use, followed by the Navy and Marine Corps; there is no significant difference between reported cannabis use in the Navy and Marine Corps.

When reported use of all drugs except cannabis is combined, Air Force personnel reported the lowest use. Army personnel reported the next lowest use, Navy personnel are next in the ranking, and Marine Corps personnel reported the highest use of drugs excluding cannabis.

Although this analysis does not modify the absolute extent of the problem, it does provide an informative view of the relative prevalence of sub-

[3]Based on a September 30, 1979, profile.
[4]Based on a December 31, 1978, profile.
[5]Based on a March 31, 1980, profile.

Table 15. Substance use among standardized military populations
(Percent of enlisted personnel with less than 48 months of service)

Substance*	Army	Navy	Marine Corps	Air Force
Alcohol use	88.9	95.6	**92.8	93.6
Cannabis use	46.6	51.9	50.9	40.4
Any drug except cannabis	27.9	32.6	37.2	22.3

*Based on 12-month use questions; categories are not mutually exclusive.
**Underlined percentages are not statistically significantly different at $\alpha = .05$.

stance use in the various military services. The analysis indicates that, when the demographic factors are accounted for, the prevalence rates for drug and alcohol use are not substantially different from the nonstandardized sample. This suggests that there are factors other than demographics that affect the rates of drug and alcohol use.

Summary and Discussion

The primary analysis of the survey data detailed some facts and figures that, if not already known, were at least suspected; it also pinpointed some areas that gave cause for grave alarm, and in a few instances, it provided some cause for relief.

First and foremost, the survey showed that drinking to some degree or another is widespread in the Armed Forces. Ninety-two percent of the surveyed population reported drinking some alcohol in the past year, and beer was the beverage of choice, followed by hard liquor and wine.

The survey revealed that 7 percent of the population was alcohol dependent. That represents about 144,000 members of the active duty military population. What is most shocking, however, is the number of servicemembers who reported some form of work problems caused by alcohol. Twenty-seven percent reported work impairment of some type during the past year. Three percent claimed they were drunk on the job on 40 or more different days in the past year.

The work impairment record of the junior enlisted personnel is of considerable concern to the DoD. These servicemembers, the E1s to E5s, are the workers in the military services; they do the day-to-day, hands-on labor, and it is vital in this era of ever-increasing technological complexity that these workers be mentally alert. Peoples' lives depend on the clear-witted thinking and actions of the E1s to E5s. Yet it is in this population that the most serious deficiencies are found. Ten percent of the junior enlisted population is drug dependent, compared with 3 percent of the senior enlisted force and an insignificantly small percentage of warrant and commissioned officers. Thirty-one percent of the E1s to E5s report some work impairment, and 15 percent claim they were drunk on the job sometime in the past year. However, a bright note appears in the figures for other grade groups—the percentages of those reporting drunkenness on the job were insignificant.

Finally, it was learned that the civilian and military population differed little in their use of alcohol. Small comfort is taken from this fact. If the military is to provide a truly combat-effective force, the extent of excessive use of alcohol in the junior population must be reduced.

The secondary analysis also produced a number of enlightening facts; in addition, it confirmed some that were previously only suspected. The secondary analysis demonstrated a positive correlation between adverse work consequences and use of both drugs and alcohol. In general, the greater the use of drugs or alcohol, the higher the number of adverse consequences reported.

Analysis of the survey questions also revealed that the most important reason given for not drinking was fear of what drinking might do to one's health, and the least important reasons given were that the respondent was medically restricted from drinking or that his friends disapproved. This gives cause to wonder just what peer pressure does have to do with the extent of alcohol use. Alcohol cost did enter the picture; about half of those who said they did not use alcohol said they abstained because alcohol was too costly.

Of those who did drink, the reason given by most was that alcohol relaxed them. The next most frequent reasons given were that they drink to be friendly or to be social. The least important reasons given for drinking were to increase self-confidence and because there were frequent happy hours. The last tends to discount the theory that happy hours, periods when drinks are sold at reduced price in military clubs, are a prime cause of excessive alcohol consumption. Of interest is that the occasional or light drinker related his or her drinking more to social reasons than to personal needs. The reverse was true of the dependent drinker.

The percentage of respondents who reported they required medical treatment for either a drug or an alcohol problem was small; only 1.9 percent visited a doctor for a drinking problem. Yet, in

absolute figures, this percentage represents a large number of military personnel: about 39,000.

Adverse promotion actions, adverse efficiency reports, and punishment under the Uniform Code of Military Justice are the work consequences most often associated with cannabis use and heavy alcohol use. The next most frequently reported consequence was involvement in accidents; however, the association with alcohol was not conclusive.

The DoD recognizes its responsibility for helping those dependents who have a drug or alcohol problem. From the answers of the survey respondents, it is evident that many dependents need help but are not getting it, at least in Government programs. Two and two-tenths percent of the married respondents said a family member needed help. This represents 29,500 to 36,800 individuals.

Differences were noted in the prevalence of alcohol use among the services. It was felt that service demographics may have some skewing effect on the prevalence statistics, so the service demographics were normalized and the prevalence figures were reanalyzed. It was found that the service demographic characteristics do not, in fact, bias the prevalence rates to any significant degree, so that there must be other reasons for the differences.

In conclusion, the 1980 drug and alcohol abuse survey of the Armed Forces provided a wealth of information about the alcohol use habits of the military population in the important areas of prevalence of use and adverse consequences of use. It also provided a basis on which the DoD can construct a time line of alcohol use data. The second in a planned series of biennial surveys is scheduled to be administered in the spring of 1982. The same types of data will be collected, analyzed, and used to shape DoD policies and military service programs in the continuing effort to prevent and treat alcohol problems.

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The Military Response to Alcohol and Drug Problems

While the extent of alcohol problems is only slightly greater in the military than among civilians, the consequences of alcohol-related impairment of servicemembers can be devastating. The Department of Defense's (DoD) concern with alcohol use and its effect on the fighting force of the Nation is reflected in the fact that nearly $4.8 million will be spent in FY 1981 to educate the military and DoD civilian work force to the dangers of the alcohol threat, and an additional $45 million will be spent on treatment and rehabilitation of those with alcohol and other drug problems. All branches of the Armed Forces operate alcohol and drug problem prevention, intervention, and treatment programs.

In 1972, the DoD adopted an alcohol abuse and alcoholism policy, in accordance with Title V of P.L. 92-129 and Title II of P.L. 91-616, acknowledging that alcoholism is a treatable disease. Alcohol abuse and alcoholism policy for the Department is the responsibility of the Assistant Secretary of Defense for Health Affairs, and each of the services and DoD agencies implements its own program within the policy guidelines.

Although alcohol programming was instituted in some areas of the military as early as 1965, the services began to systematically develop alcohol programming in the early 1970s. Since that time, each of the services has developed comprehensive efforts that vary in approach but provide a full range of prevention, early intervention, and treatment services to military and civilian personnel, as well as to their family members.

A major DoD emphasis in recent years has been placed on preventive education for employees and family members. For instance, the DoD Dependent School System has initiated an alcohol education approach that involves teens in teaching their peers about alcohol use and consequences related to drinking.

Early intervention has also received increasing attention by the DoD, as a growing body of evidence in the private sector has indicated that people reached before alcohol problems become chronic are very responsive to treatment efforts.

In the area of treatment and rehabilitation, about 50,000 military and 2,500 civilian staff will receive care for alcohol-related problems this year. A work force of 2,500 military and civilian personnel staff a system of 54 residential and 420 nonresidential alcohol and drug treatment and rehabilitation centers.

The treatment programs basically follow the same approach as do civilian programs and realize a treatment success rate ranging from 75 to 92 percent.

Assessing the Contributions of Involving "Significant Others" in the Treatment of the Female Alcoholic

Patrice M. Muchowski-Conley, Sc.D.

Increased numbers of female alcoholics are participating in alcoholism treatment programs, raising questions about how appropriate traditional, male-oriented treatment strategies are for women. Should females be treated as a distinct group or be treated in conjunction with male alcoholics? Is group treatment more effective for women than individual treatment? Should females be treated individually or as part of a family unit?

The impact of involving significant others in the treatment of the female alcoholic is a question of particular relevance, for several reasons. Previous research shows that female alcoholics often are prompted to seek treatment by interpersonal difficulties (Dulfano 1978; Gomberg 1974) and are more likely than males to lose treatment gains when they return to the home and community (Burtle et al. 1974). Therefore, it seems that interpersonal relationships play an important role in motivating female alcoholics, in both positive and negative directions.

Based on these observations, a study was initiated to explore the potential benefits of involving significant others in the female alcoholic's treatment. The results highlight the complexity of significant other involvement in the treatment of the female alcoholic.

Author's Note: This study was supported by a grant from the Rehabilitation Research and Training Center, Boston University.

Methodology

Thirty-six female recovering alcoholic subjects participated in this study. All had completed a 14-day inpatient treatment program during a 3-month period in 1979 at Mount Pleasant Hospital, a private alcoholism facility located several miles north of Boston in Lynn, Massachusetts.

All females discharged from the hospital during the 3 months were informed of the study by letter in November of 1979. Female alcoholics who were residents of halfway houses, rehabilitation facilities, or other institutions were deemed ineligible, since the therapeutic activities of the different programs could confound results. A followup telephone call explained the purpose of the study and determined the subject's interest. If the subject was interested, she was asked to identify "the most important person" in her life, and was asked if this person could be helpful by becoming involved in her treatment. If so, this person became the significant other for the study. Permission was obtained to contact the significant other and assess his or her interest and willingness to participate, since several assessment instruments required information from the significant other.

Screening interviews were scheduled for both recovering alcoholic subjects and significant others. If a significant other was experiencing a problem that would interfere with active participation in the study—such as active alcoholism or drug addiction—he or she was excluded and the recovering alcoholic subject was helped to enlist the participation of another significant other.

Table 1. Group Membership

Number of subjects	Group 1	Group 2	Control
Assignments	12	12	12
Participants	10 + 5*	2	10

*Represents five female subjects originally assigned to Group 2 who refused to participate with a significant other.

The average age of the female subjects was 45. Fifty-nine percent were married, 25 percent single, 7 percent separated, 7 percent widowed, and 2 percent divorced. Seventy percent were actively employed outside the home during the time of this study. The average duration of problem drinking was 8½ years, and the average age at first drink was reported to be age 19. Seventy percent of the females reported previous treatment for alcoholism.

The breakdown of significant others consisted of 49 percent husbands, 18 percent children, 7 percent boyfriends, 7 percent sisters, and the remaining classified as friends. Six of the significant others had drinking problems.

The subjects were randomly assigned to one of three groups. Group 1, comprised only of female recovering alcoholic subjects, was a 12-session skills training group; Group 2 included both female recovering alcoholic subjects and significant others and provided the same skills training as Group 1, and the third group was a control group of female recovering alcoholics who participated in no training.

Dropouts

Once subjects were notified of their group status (female-only group, female plus significant other group, or control group), an interesting dropout phenomenon occurred. Although 36 women had agreed to participate in the study, only 27 completed the group sessions, including 15 Group 1 subjects, 2 Group 2 subjects, and 10 controls (see table 1).

In Group 1, two subjects dropped out of training during the first two sessions. Several incidents reduced the number of subjects in Group 2. In two cases, couples assigned to that group did not participate in any training sessions. Six of the female recovering alcoholics assigned to Group 2 declined to participate with their significant others, though they had agreed to assignment to such a group. Five of these said they wished to participate in skills training, but only with other recovering alcoholic females. A separate group was developed to provide training for them, although they were considered members of Group 1 for statistical purposes. In two other cases, significant others assigned to Group 2 refused to participate though the recovering alcoholics were willing to participate. Two subjects assigned to the control group declined to participate after they had been advised of their status.

Discussion

The large subject loss in Group 2 rendered it impossible to accurately assess the contributions of significant other involvement in alcoholism treatment. The reasons for the high dropout rate required close examination, however, and dropouts were contacted to determine their reasons for nonparticipation.

The six females who refused to participate in Group 2 explained that their decisions were based on fear of discussing their alcohol problem with significant others. They viewed themselves as being misunderstood by their significant others and thought group discussion would increase difficulties rather than solve them. Though they had agreed to accept random assignment, their clear hopes were to be assigned to Group 1. Five of these women felt a female-only group would offer important support that could not be gained from other sources.

The two significant others who refused to participate in Group 2 were husbands suspected of having alcohol problems themselves. Since their alcohol problems had not been specified during the screening interviews, they had not been excluded. It is quite likely they refused to participate because they feared being "discovered." The two couples who did not appear for any training were unwilling to be interviewed about their reasons for nonparticipation.

The two couples who did participate in Group 2 were married, and both husbands admitted to having had alcohol problems. One husband was a recovering alcoholic who had facilitated his wife's treatment. The other husband expressed concerns about his own drinking and was working to achieve abstinence. Apparently the fact that problems with alcohol were not confined to the female decreased the fear of joint participation on the part of

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the recovering alcoholic females. And since both husbands had admitted to having had an alcohol problem, discovery by other group members did not pose a barrier to their group participation as it did for "hidden" alcoholics.

Though attempts were made by the investigator to persuade those significant others who did not want to participate to continue their participation, other approaches to the situation might have been more productive. The tendency of some potential participants to shy away from group involvement perhaps could be counteracted by arranging discussions with people involved in a similar group, explaining benefits they have derived from participation. Though the purpose and focus of the skills groups for couples were explained in the screening interview, allowing potential members an opportunity to observe an actual group session might also have reduced apprehension.

The five female recovering alcoholic subjects who declined to participate with their significant others were allowed to participate in an all-female group; all of them completed training. Formation of a similar group for significant others might have provided them an option that may have been viewed as less threatening. It is interesting to note that none of the females assigned to the female-only Group 1 asked to participate with significant others. This group was perceived as comfortable and supportive both by participants originally assigned to this group and by subjects wishing to participate in this group.

Conclusions

Several recommendations can be formulated based on these findings. First, it may be more profitable to involve the significant other in treatment when the female first enters the treatment system. Waiting until she is discharged from an inpatient setting risks missing a critical opportunity to facilitate involvement even if only on a limited basis. In a crisis situation such as hospitalization, significant others may be very supportive, this support and predisposition for involvement may diminish when the crisis abates. Telling the significant other that he or she is not to blame for the alcoholic's problem may increase the likelihood of support. Second, significant other involvement can take many forms. It may be that many female recovering alcoholics and their significant others need peer support in the early stages of recovery. Offering concurrent rather than conjoint training may prove productive, as well as pave the way for eventual conjoint involvement.

Different types of issues arise in groups, depending upon the participants, and these should be considered when planning groups. In this study, for example, the discussion content in the group for couples markedly deviated from the content in the female-only group. In the couples group, discussion dealt with communication problems, family problems, and sexual problems; the female-only group spent much time discussing personal feelings about being alcoholic and the stigma experienced in many areas of the participants' lives.

In planning groups, one needs to consider the relationship between the female alcoholic and her significant other. A homogeneous group of significant others (for example, husbands of recovering alcoholics) could facilitate identification and support among group members because of the similarity of issues. If members share similar problems, their learning may increase from observing each other develop and implementing alternative solutions to common problems. A heterogeneous group consisting of husbands, children, and friends may jeopardize potential gains by fragmenting the group members' focus. Involving significant others in the treatment process requires an understanding of the nature of the alcoholism problems, the nature of the relationships, and the goals sought by the members of the group.

These recommendations are based on the premise that the involvement of significant others in certain situations can be beneficial. It must be remembered, however, that the benefits of this type of involvement may not apply in all situations. Although the females who refused to participate in the significant other group in this study may have missed an important opportunity for positive reinforcement from family members, they chose the services they viewed as most helpful in their specific circumstances. At least until further research assesses the relative importance of differing types of significant other involvement, letting clients and significant others make decisions regarding involvement or noninvolvement may contribute to the best outcome.

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Legal Minimum Drinking Age Changes in the United States: 1970-1981

Alexander C. Wagenaar, Ph.D.

In the past decade the minimum legal drinking age for purchase and consumption of alcoholic beverages has been the subject of frequent debate, usually centered on the public health consequences of different minimum drinking ages. In the early 1970s many States lowered the drinking age, usually from 20 or 21 to 18 or 19, as part of a nationwide trend lowering the age of majority.

As debate in public policy and academic arenas ensued concerning the effects of the reduced drinking age on the incidence of alcohol-related problems among youth, numerous empirical investigations were conducted. Results generally showed significant increases in alcohol-related motor vehicle crash involvement among young drivers after reductions in drinking age (Bako et al. 1976; Cucchiaro et al. 1974; Douglass 1974; Douglass and Freedman 1977; Flora et al. 1978; Illinois Department of Transportation 1976; Lynn 1981; Naor and Nashold 1975; Schmidt and Kornaczewski 1975; Shattuck and Whitehead 1976; Warren et al. 1977; Whitehead 1977; Whitehead et al. 1975; Williams et al. 1974). Several studies also found indications of increased alcohol consumption and increased rates of admission to alcoholism treatment programs after drinking ages were lowered (Barsby and Marshall 1977; Douglass and Freedman 1977; Maisto and Rachal 1980; Smart 1977, 1980; Smart and Schmidt 1975; Wolfe and Chapman 1973).

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As a result of emerging research evidence and changes in the political and social climate, a number of States raised the drinking age in the late 1970s and early 1980s. Research on the effects of this return to higher drinking ages has revealed alcohol-related crash involvement among young drivers decreased significantly (Wagenaar 1980, in press; Williams et al. 1981).

Although increasing research evidence indicates that the minimum legal drinking age has a measurable effect on the incidence of alcohol-related public health problems, there is still considerable controversy about what is the most appropriate age for legal purchase and consumption of alcoholic beverages. Research efforts are continuing, replicating earlier studies by analyzing the experience of additional States as they change the drinking age, and identifying in greater detail the nature of the effects of drinking age laws.

Research on the legal drinking age frequently involves comparisons between States that have changed the drinking age and States that have not. Therefore, it is important to have accurate information concerning legal drinking age changes in the various States. Since a review of the literature on legal drinking age reveals substantial differences in reports of drinking age laws and changes, this investigation was undertaken to obtain accurate information on drinking age changes directly from each of the 50 States and the District of Columbia regarding (1) which States have changed their minimum drinking age, (2) when the legal changes were implemented, and (3) the age groups and types of alcoholic beverages affected by the changes.

Differing Reports

Conflicting descriptions of legal changes are clearly evident in the published literature on the minimum drinking age. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) (1976) reported that 24 States had reduced the drinking age between June 1970 and May 1976; another NIAAA report (1978), however, said a total of 38 States had reduced the drinking age during the 1970-1976 period; neither report identified the source of the information. The Illinois Department of Transportation (1976) reported that 24 States had reduced the drinking age; although no citation was given, that table is identical in form to that found in the NIAAA report (1976). Smart and Goodstadt

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(1977) and Smart (1977) reported that 26 States had implemented reduced drinking ages; no citations were provided.

Half of the United States lowered the drinking age between 1970 and 1973, according to Whitehead (1977), citing NIAAA (1973). Barsby and Marshall (1977) stated that 22 States had lowered the drinking age for distilled spirits between 1970 and 1975; a table in the same article, however, lists 25 States that apparently meet these criteria. Rooney and Schwartz (1977), citing a Distilled Spirits Council of the United States (DISCUS) report (1977), indicated that 27 States had reduced the drinking age for all alcoholic beverages, and a total of 35 States had reduced the legal age for at least one beverage type (i.e., beer, wine, or distilled spirits). Cannon (1979) listed 28 States that had lowered their drinking age. "As many as 26 States" lowered the minimum drinking age according to Yoakum (1979); the source of the information was not indicated. Wagenaar (1980), citing NIAAA (1976) and unpublished information provided by NIAAA's National Clearinghouse for Alcohol Information, reported that 35 States had reduced the drinking age. Wechsler and Sands (1980) said that 29 States had lowered the drinking age between 1970 and 1975, apparently basing their statement on information provided by DISCUS. NIAAA (1981) reported that 28 States had reduced the drinking age between 1970 and 1975.

It is clear that a reader of the drinking age literature would be confused as to the number of States that had lowered the drinking age in the 1970s. This lack of a definitive accounting can produce serious problems for those seeking to analyze research related to drinking patterns. For example, Smart (1977) compared beverage sales in States that lowered the drinking age with sales in States that did not change the drinking age during the time period under investigation. It appears that four States he analyzed as comparison States not changing the drinking age did in fact lower the legal age during the study period. Such confusion complicates interpretation of the findings.

Since the literature on the minimum drinking age does not include reports of any original data collection on drinking age changes, the present survey was initiated in an attempt to clarify recent changes in the legal minimum drinking age in the United States.

Methods

Legal staff in the legislative service bureau of each of the 50 States and the District of Columbia were interviewed by telephone. Respondents were asked about all changes in legal minimum drinking age in their State between January 1970 and April 1981. Information recorded included effective date, age categories affected, and type of

Drinking Age Increases Lead to Traffic Crash Decreases

In two States where the minimum drinking age was raised, alcohol-related automobile crashes involving teenagers dropped sharply, according to researchers conducting an evaluation of the effects of raised drinking ages in Maine and Michigan. The study is being conducted by the Highway Safety Research Institute in Ann Arbor, Michigan, and is funded by a grant from NIAAA.

In both States, alcohol-related crashes involving property damage decreased after the legal drinking age was increased. In Michigan, alcohol-related crashes involving injuries or fatalities also decreased.

According to Alexander Wagenaar of the research team, the results are of interest to those concerned with preventing alcohol-related problems among youth. "On the basis of traffic accident results, it appears that raising the drinking age is an effective countermeasure for reducing this alcohol-related problem among youth," Wagenaar noted in an interview.

In the past, roughly a dozen major studies have looked at the effects of lowering the drinking age and generally found that crashes involving youngsters increased. The Highway Safety Research Institute study is the first major effort to discover whether the reverse held true—that raising the legal drinking age leads to a decrease of such accidents. The researchers have analyzed statistics on alcohol-related motor vehicle accidents both before and after drinking age changes occurred in the two States.

They have found that alcohol-related crashes involving only property damage decreased 17 to 22 percent in Maine among 18- and 19-year-olds in the first year after the State raised the minimum drinking age from 18 to 20 years. This represents 61 to 90 fewer crash-involved drivers, Wagenaar said.

In Michigan, the State raised the drinking age from 18 to 21 in 1978. Alcohol-related property damage accidents dropped 11 to 22 percent among 18- to 20-year-olds during the following year. This represents 725 to 1,617 fewer crash-involved drivers, he said.

The frequency of alcohol-

alcoholic beverages (low alcohol beer, regular beer, light wine, fortified wine, and distilled spirits) covered by each change in drinking age. In addition, copies of the relevant statutes were obtained and reviewed to ensure that the information obtained in the interviews was consistent with the statutes. Information provided by the States also was compared with lists of drinking age changes published in the literature. Any differences were clarified through followup telephone calls. It was quite difficult to obtain accurate information without careful cross-checking of sources. In fact, some respondents provided incorrect information on legal changes in their States during the first telephone interview. More than half the States required followup calls; several were contacted more than twice before an accurate and complete account of drinking age changes was obtained.

Results

Overall, 29 States reduced the legal minimum drinking age between 1970 and 1975, in contrast to the published literature reviewed above, which reported that as few as 24 or as many as 38 States lowered the drinking age in the 1970s. No State has lowered the drinking age since 1975. Twenty-three States lowered the drinking age for all alcoholic beverages in the early 1970s, most frequently from 21 to 18 or 19 (see table 1). Two of these States, Iowa and Montana, lowered the drinking age in two steps, first from 21 to 19, and later to 18. Illinois and Maryland reduced the legal age for purchase of beer and wine only, South Dakota lowered the age for purchase of low-alcohol-content beer only, and Virginia reduced the drinking age for regular beer only. West Virginia reduced the legal age for distilled spirits to 18; the age for purchase of beer and wine had been 18 since 1935. Wisconsin lowered the drinking age to 18 for all beverages except beer, which 18-year-olds had been legally permitted to purchase since 1933. In Oklahoma, the drinking age for low-alcohol-content beer was lowered to 18 for male drinkers as a result of a U.S. Supreme Court ruling disallowing differential legal minimum drinking ages for males and females (see table 2); this change was not counted in our totals because it was not State initiated.

As noted earlier, there has been a trend toward raising the drinking age in recent years. Between September 1976 and April 1981, 13 States increased the minimum age for purchase of all alcoholic beverages (see table 3). Rhode Island increased the drinking age in two steps, from 18 to 19 in July 1980, and from 19 to 20 in July 1981. In addition, two States raised the drinking age for specific beverage classes. Illinois raised the age for beer and wine to 21 (the age for distilled spirits was already 21), and Virginia increased the minimum age from 18 to 19 years for purchase of beer for off-premise con-

related crashes in which injuries or fatalities occurred also declined significantly in Michigan the year after the drinking age was raised. There were 11 to 28 percent fewer such crashes, representing as many as 1,726 drivers. There was no significant decline in Maine.

For comparison purposes, the researchers checked the data against the frequency of alcohol-related crashes in Pennsylvania and New York, where the legal drinking ages consistently have been 21 and 18 years, respectively. They also compared the age group presumably affected by changes in Maine and Michigan with younger and older age groups in the State.

This cross-checking assured control of outside factors such as fuel shortages, economic recessions, and seasonal effects that might have accounted for the changes in numbers of accidents, Wagenaar said. Thus, even if accidents were down in all age groups, if the reduction was substantially greater among young drivers in Michigan, the increase in drinking age most likely was the reason, he said.

The wide range of reductions cited by the researchers is the result of the various types of data used to measure alcohol-related crashes, he said. In some cases police reports were used, since in Michigan, the police must show in their reports whether a driver had been drinking. However, in other States such information is optional, so alcohol involvement in accidents was estimated, based on the number of nighttime accidents involving a single car and male driver, because these factors characterize alcohol-related accidents among young drivers, he said.

As part of their major evaluation, the researchers also are looking at changes in consumption, estimated from beverage sales in States that have raised their drinking ages. Results are more ambiguous since there is no breakdown of sales data for specific age groups, and tax structures fluctuate in the various States. However, Wagenaar observes, "If a particular age group is drinking less or not at all, sales should decrease."

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Nancy Johnson, NCALI

Table 1. States lowering the minimum legal drinking age: 1970-1975

State	Effective date	Description of change
Alabama	7/75	21 to 19—all beverages
Alaska	9/70	21 to 19—all beverages
Arizona	8/72	21 to 19—all beverages
Connecticut	10/72	21 to 18—all beverages
Delaware	7/72	21 to 20—all beverages
Florida	7/73	21 to 18—all beverages
Georgia	7/72	21 to 18—all beverages
Hawaii	3/72	20 to 18—all beverages
Idaho	7/72	21 to 19—wine and distilled spirits; 20 to 19—beer
Illinois	9/73	21 to 19—beer and wine only
Iowa	4/72	21 to 19—all beverages
Iowa	7/73	19 to 18—all beverages
Maine	6/72	20 to 18—all beverages
Maryland	7/74	21 to 18—beer and light wine only
Massachusetts	3/73	21 to 18—all beverages
Michigan	1/72	21 to 18—all beverages
Minnesota	6/73	21 to 18—all beverages
Montana	7/71	21 to 19—all beverages
Montana	7/73	19 to 18—all beverages
Nebraska	6/72	20 to 19—all beverages
New Hampshire	6/73	21 to 18—all beverages
New Jersey	1/73	21 to 18—all beverages
Rhode Island	3/72	21 to 18—all beverages
South Dakota	7/72	19 to 18—3.2 beer only
Tennessee	5/71	21 to 18—all beverages
Texas	8/73	21 to 18—all beverages
Vermont	7/71	21 to 18—all beverages
Virginia	7/74	21 to 18—beer only
West Virginia	6/72	21 to 18—distilled spirits (beer and wine were 18 since 1935)
Wisconsin	3/72	21 to 18—all beverages except beer, which has been 18 since 1933
Wyoming	5/73	21 to 19—all beverages

sumption. Overall then, as of April 1981, 15 States have increased the minimum drinking age since 1975. Legislation to raise the drinking age is currently under consideration in several other States.

It is clear from this investigation that most previous accounts of changes in minimum drinking age laws included some inaccuracies. Differing definitions of what constitutes a change in drinking age, and lags between the time articles are written and they are published may explain some of the discrepancies. For example, some reports apparently double-counted those States that lowered the drinking age in two steps. In Iowa and Montana the drinking age was reduced in two steps, first from 21 to 19 and later from 19 to 18 (table 1). Such a two-step drinking age reduction might be counted as two separate legal drinking age changes.

Whatever the cause of inaccuracies, a serious problem is caused when an inaccurate report is used by numerous other authors as a source for information on drinking age changes. An additional problem is created when authors do not reveal the source of their information, making it impossible to verify accuracy of the report.

This study can provide a base from which the National Institute on Alcohol Abuse and Alcoholism or another national body can maintain regularly updated and verified information on changes in legal minimum drinking age and other alcohol beverage control laws in the various States. It will also be helpful if those reporting on drinking age laws indicate the source of their information. It is important that information on alcohol beverage control laws, such as the legal minimum drinking age for purchase and consumption of alcoholic beverages, be accurate if we are to make reasonable and informed decisions on important public policy issues.

Table 2. Current minimum legal drinking ages: April 1981

State	Beer		Wine		Distilled spirits
	3.2% or less alcohol	Over 3.2% alcohol	Light	Fortified	
Alabama	19	19	19	19	19
Alaska	19	19	19	19	19
Arizona	19	19	19	19	19
Arkansas	21	21	21	21	21
California	21	21	21	21	21
Colorado	18	21	21	21	21
Connecticut	18	18	18	18	18
Delaware	20	20	20	20	20
District of Columbia	18	18	18	21	21
Florida	19	19	19	19	19
Georgia	19	19	19	19	19
Hawaii	18	18	18	18	18
Idaho	19	19	19	19	19
Illinois	21	21	21	21	21
Indiana	21	21	21	21	21
Iowa	19	19	19	19	19
Kansas	18	21	21	21	21
Kentucky	21	21	21	21	21
Louisiana	18	18	18	18	18
Maine	20	20	20	20	20
Maryland	18	18	18	21	21
Massachusetts	20	20	20	20	20
Michigan	21	21	21	21	21
Minnesota	19	19	19	19	19
Mississippi	18 a	21	18 a	21	21
Missouri	21	21	21	21	21
Montana	19	19	19	19	19
Nebraska	20	20	20	20	20
Nevada	21	21	21	21	21
New Hampshire	20	20	20	20	20
New Jersey	19	19	19	19	19
New Mexico	21	21	21	21	21
New York	18	18	18	18	18
North Carolina	18	18	18	21	21
North Dakota	21	21	21	21	21
Ohio	18	21	21	21	21
Oklahoma	18 b	21	21	21	21
Oregon	21	21	21	21	21
Pennsylvania	21	21	21	21	21
Rhode Island	20	20	20	20	20
South Carolina	18	18	18	18	21
South Dakota	18	21	21	21	21
Tennessee	19	19	19	19	19
Texas	18	18	18	18	18
Utah	21	21	21	21	21
Vermont	18	18	18	18	18
Virginia	18 c	18 c	21	21	21
Washington	21	21	21	21	21
West Virginia	18	18 d	18	18	18
Wisconsin	18	18	18	18	18
Wyoming	19	19	19	19	19

a Drinking age is 18 for beer or wine that is 4% or less alcohol by weight.
b Prior to December 1976, the age was 18 for females and 21 for males. This sex discrimination was ruled unconstitutional by the U.S. Supreme Court, having the effect of lowering the age to 18 for males [Craig v. Boren, U.S. Okl. 97 S. Ct. 451 (1976)].
c Eighteen for on-premise consumption, 19 for off-premise consumption.
d Effective June 1980; beer over 3.2% was illegal in West Virginia before that date.

Table 3. States raising the minimum legal drinking age: 1976-1981

State	Effective date	Description of change
Florida	10/80	18 to 19—all beverages
Georgia	9/80	18 to 19—all beverages
Illinois	1/80	19 to 21—beer and wine only
Iowa	7/78	18 to 19—all beverages
Maine	10/77	18 to 20—all beverages
Massachusetts	4/79	18 to 20—all beverages
Michigan	12/78	18 to 21—all beverages
Minnesota	9/76	18 to 19—all beverages
Montana	1/79	18 to 19—all beverages
Nebraska	5/80	19 to 20—all beverages
New Hampshire	5/79	18 to 20—all beverages
New Jersey	1/80	18 to 19—all beverages
Rhode Island	7/80	18 to 19—all beverages
Rhode Island	7/81	19 to 20—all beverages
Tennessee	6/79	18 to 19—all beverages
Virginia	7/81	18 to 19—off-premise beer only

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Alcohol, Drugs, and Spinal Cord Injury

James J. O'Donnell, Jonathan E. Cooper, M.D., John E. Gessner, M.D., Isabelle Shehan, R.N., and Judy Ashley, M.S.W.

Alcohol and drugs appear to be a major, but seldom discussed, factor in spinal cord injuries. A study described in this article revealed that, of 47 traumatic spinal cord injury patients treated in a 6-month period at Baltimore's Montebello Center Spinal Cord Unit, 29—or 62 percent—were identified as having alcohol- or drug-related injuries. This confirmed staff observations on the scope of this problem; however, a thorough search of the literature published in the last 10 years revealed that no studies linking alcoholism or drug abuse to spinal cord injury have been published.

The study conducted at the Montebello Center, as well as the observations of the authors, indicates that involvement with alcohol or drugs is common among patients. Although the spinal cord unit is part of a State hospital, the patients appear representative of spinal cord injury patients in general; most have been transferred from local general hospitals and they resemble other patients described in the literature with respect to income, IQ, marital status, employment, and other demographic characteristics.

The study was undertaken to try to determine the relationship of alcohol and drugs to the causes of spinal cord injury; the effects of continued use of alcohol and drugs after injury, both during treatment and during leaves of absence from the center; and the effects of alcohol and drug use on short- and long-term rehabilitation goals. The treatment program at the center attempts to address the issues raised by patients' drug and alcohol problems.

Between July 1 and December 31, 1980, 54 patients were treated in the physical rehabilitation program on the 22-bed spinal cord injury unit at Montebello Center. Only those patients admitted for rehabilitation of moderate or severe paraplegia or quadriplegia resulting from acute trauma were selected for the study. Paraplegics have lost use of their legs and lower part of the body, and quadriplegics have lost use of their legs and, to varying degrees, their arms and hands. The group comprised 47 patients, 39 males and 8 females. Five of the patients were 10 to 20 years old; 22 were 20 to 30 years old; 6 were 30 to 40 years old; and 14 were over 40 years of age. The causes of trauma among the men included 13 traffic accidents, 8 falls, 7 diving accidents, 7 gunshot wounds, and 4 sports injuries. Six of the eight women had experienced falls, and the other two had been involved in traffic accidents.

Alcohol and Drug Involvement

The chart of each patient was reviewed. The research group identified the patients' drinking habits based on reports obtained from the patients, their families, and the referring hospitals where they were first treated (using toxicology screens when available), as well as clinical observations. This information included whether patients had a prior history of alcohol or drug abuse (greater than moderate or occasional use); had alcohol or drugs in their bodies at the time of their injury; and had begun, resumed, or continued the use of alcohol or drugs since their injury. The results are presented in table 1.

There is a tendency for most patients to resume using alcohol and drugs later in the rehabilitation process particularly as they become more physically active and as social interaction increases. This, of course, brings on a multitude of problems. Both alcohol and marijuana are central nervous system depressants that interfere with motor activities, especially those that are learned. Patients who already have a tendency to be

Table 1. Alcohol and drug-use among 47 patients

Prior history of abuse	*Use at injury*	*Resumed use*
41 patients	9 patients (toxicology proven)	32 patients (staff observation and family or self-report)
	18 patients (self or family report)	
	5 patients (staff suspicion*)	
	32 patients	

*On the basis of prior history, circumstances of injury, or subsequent behavior.

The use of alcohol or drugs when first hospitalized seems to be in a temporary "hold" pattern with the majority of patients because they are concentrating on coping with their trauma and the rigorous requirements of the rehabilitation program. There are also barriers to obtaining and using alcohol or drugs; opening a bottle of beer, for example, requires significant physical dexterity or the help of another person. There often is denial of problems as patients express the feeling that since they are not drinking or using drugs now, the problem no longer exists. This denial is further demonstrated and reinforced by their reluctance to attend an AA meeting held weekly at the hospital, a problem that needs to be addressed in long-term followup and study.

depressed because of their physical disability do not get over this depression by using alcohol and other drugs. Also, because they are frequently "hung-over," these patients do not participate in a motivated manner in the physical rehabilitation program.

Use of alcohol and other drugs also interferes with the prescribed medication, sometimes in dangerous ways. The patient who drinks while taking warfarin compounds to prevent blood clot formation risks life-threatening internal bleeding because alcohol's interaction with blood clotting substances may further decrease clotting activity. Many of the medications used to control muscle spasticity also have central nervous system effects that, in combination with alcohol and other illicit drugs, may be additive.

The sheer volume of urine produced by heavy beer drinking can totally ruin an intermittent catheterization program. In the past, a catheter, or tube inserted into the bladder to drain urine, often remained indefinitely in patients, predisposing them to infections, a common cause of death among spinal cord patients. Today, as patients regain bladder reflexes, they are weaned off constant drainage and eventually may need catheterization only every 6 to 8 hours. Men may be able to use a noninvasive condom-type catheter that fits over the penis, and some women regain enough control that catheterization is not needed. Large volumes of urine from drinking, however, stretch the bladder so that useful reflexes are lost and chances for getting off constant drainage are ruined. Also, a distended bladder can trigger a reflex that causes blood vessels to constrict, resulting in excessive and in some cases life-threatening high blood pressure.

Disulfiram (Antabuse) therapy must be either avoided or very carefully monitored because of the dangers of severe alcohol-disulfiram reactions in an already disabled individual. Suicide by this means also could be viewed as a "way out" by a depressed patient with a drinking problem.

Many of these patients prior to injury were physically active, daring individuals. After injury, their tendency to take risks and ignore the consequences is often exhibited as they ask for or accept prescribed drugs that, in some cases, they know could be life threatening if ingested while under the influence of alcohol or other drugs. These interactions can be particularly dangerous to the spinal cord patient who already has an impaired autonomic nervous system and altered metabolic state. Constant nursing surveillance is crucial to avoid adverse interactions with tranquilizers, sedatives, narcotics, antibiotics, or anticoagulants in patients who may have been given a drug or alcoholic beverage by a well-meaning friend, a relative, or even a staff member. Well-meaning visitors often perceive alcohol and drug use as a way to provide their loved ones with some "enjoyment" and "normalcy."

The staff attempts to identify alcohol and drug use early from admission data and intake interviews. We use a team approach to treatment that involves nurses, physicians, occupational and physical therapists, social workers, and an alcoholism coordinator. Each patient's status is reviewed monthly by the staff, and consideration of alcohol and drug use is as important as issue as are other medical and physical concerns. The alcoholism coordinator also participates in weekly chart rounds to help focus attention on alcohol concerns. We openly discuss alcoholism and drug abuse at the center to encourage the patient to feel that this problem should not be concealed. We feel that a part of the treatment staff's obligation is to offer the patient counseling and support in dealing with these problems. This aspect of rehabilitation, however, seems to carry the most frustration and challenge, because addictive behavior in a disabled person can be an especially difficult pattern to alter or eliminate.

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Psychosocial Concerns

As mentioned previously, persons with spinal cord injuries tend to exhibit a specific personality type. These people often are uninterested in intellectual pursuits, and their daring, thrill-seeking behavior, which often appears self-destructive, places them at high risk for injury. In turn, injuries that restrict the all-important mobility of these people are particularly difficult for them to adapt to, and the difficulty is increased because their mental and emotional reserves are poorly developed. Depression and the resulting resumption of drug taking and drinking is common following injury, and this increases the difficulty of rehabilitation.

The continued use of alcohol impairs the patient's capacity to adapt to limitations and to plan

for a return to the community. Energy, rather than being used to cope with reality, often is invested in maintaining defenses of fantasy, denial, and projection. For example, patients fantasize about walking or running again; they deny their own role in the accident or the grimness of the prognosis; and they shift the responsibility for their feelings onto others. For example, they feel helpless, yet blame physicians who are unable to bring about recovery. The inadequacy of these defenses in warding off anxiety is often disguised by alcohol consumption.

Family members as well as patients are confronted with the need to adapt to both the physical and psychological impact of injury. This can be complicated by the guilt family members may feel as a result of a perceived failure to protect a loved one from harm. Guilt also may stem from unacceptable feelings of anger toward the disabled person whose self-destructive behavior often has left other family members burdened with new roles, decreased income, and other problems. If these feelings remain unrecognized, an overprotective attitude toward the patient often will develop and interfere with rehabilitation. The cause of Richard illustrates this.

Richard is a middle-aged man who sustained quadriplegia as the result of an alcohol-related automobile accident. His elderly parents insisted on caring for him, unwilling to recognize their anger toward their son for his self-destructive behavior arising from excessive use of alcoholic beverages. A value conflict ensued, as the parents attempted to control Richard's choice of friends and leisure time activities. Feeling imprisoned by his parents, Richard requested placement in a nursing home.

Guilt also produces placatory behaviors, as family members accede to the patient's request for alcohol so the patient can experience something "pleasurable." This also serves to counteract their own feelings of helplessness.

Hospital personnel, in addition to family members, often condone alcohol use. They do this to avoid hostile encounters with patients as well as to cope with their own frustration in dealing with patients for whom there is no realistic hope of "cure." Many spinal cord injured patients without "significant others" to care for them hire live-in attendants. Obtaining alcohol and assisting the quadriplegic in consumption or in "rolling a joint" often poses a moral and legal dilemma for the abstinent attendant. Additional responsibilities are also placed on the attendant by the intoxicated individual's impaired capacity to perform activities within his or her capabilities and the increased risk of undesirable drug interactions. However, for attendants who themselves have an alcohol or drug history, their patient's substance abuse is often viewed as permission for their own indulgence, which interferes with their ability to provide adequate care.

Conclusions

Experience with spinal cord injured individuals indicates a need for alcohol and drug education, not only for the patients but for significant others; exposure to more effective methods of coping; and a new system of rewards compatible with their present needs.

We know from experience that many of these patients will require frequent hospitalizations throughout their life. Without frequent changes of position, decubitus ulcers (bed sores), permanently stiffened joints, joint contractures, pulmonary problems, and urinary tract infections commonly occur. Too often these setbacks are due to neglect, sometimes the result of sitting or lying in an alcohol- or drug-induced stupor for hours, even days on end. Many patients continue to require expert nursing care of the sort they receive at the center, but this often exceeds the capacities of their already overburdened spouses, parents, or other caretakers. And for persons with low to median incomes, the purchase of alcoholic beverages or drugs may mean other important items—medical care, medications, food, and medical-surgical supplies—remain beyond reach.

This study clearly indicates that the majority of patients with a spinal cord injury have a common problem: alcohol and drug impairment. The effects on society and families of continuing alcohol and drug abuse by spinal cord injured patients are devastating both economically and emotionally. It is of paramount importance to find the ways and means to impress on these patients the urgency of meeting alcoholism and drug abuse head on. We must address the social issues that can reduce such alcohol-induced injuries—particularly educational and preventive measures, such as tougher drunk-driving laws and their rigorous enforcement—as well as the treatment needs of spinal cord injured patients—especially training and recruiting substance abuse counselors and involving the family in the treatment program.

Holistic Therapy With "Alcoholism Families"

Donald N. Rosenberg, Ph.D.

One of the most effective and comprehensive of the many therapies available for working with alcoholics and their families is a holistic one in which the family itself is viewed as a patient. This approach assumes that problems are rooted within the entire family unit and each family member plays a role in the problem development. Although this holistic approach provides an excellent fundamental framework for working with alcoholic patients and their families, it has been the experience of therapists at the Brooklyn, New York, Veterans Administration Medical Center that without recognition of and attention to certain special characteristics and needs unique to alcoholic families, therapy can quickly degenerate into an aimless melange of horror stories, punishments, broken promises, and persistent repeated drinking. The term "alcoholism family" will be used here to describe a family in which one or more members are alcoholic.

Involvement of the alcoholic's family in the therapeutic process is very important. Consider the situation of the patient who has undergone intensive alcoholism counseling to develop a new lifestyle, that of a nondrinker, and returns to his family resolved to change things at home. Family members, for the most part, remember him while he was drinking, as the "bum," "lush," "no-good," or "n'er-do-well." The wife, usually having become the major breadwinner, has been playing dual parental roles of mother and father and has insulated herself from her husband. The children, often feeling enormous hostility, have rejected their father just as they in the past had been rejected for the bottle. Thus, the patient who has a rehabilitation program and has made an independent decision to change his lifestyle now comes home to a family that has learned to survive without him. The patient, who is now more interested in family events and who possesses new self-confidence, usually actively asserts himself, expecting to have a hand in paying the bills, managing the children, and making major family decisions. One can readily understand why problems arise that often cause the patient to return to drinking within the first few weeks of discharge.

To avoid this recidivism, therapy must begin to involve the family as soon as possible. Unfortunately, most treatment approaches pay insufficient attention to a basic purpose of family therapy; namely, helping the family organize itself so as to include the patient in a new way; that is, as a nondrinker. Therapists who attempt to directly treat the patient's drinking behavior during family therapy often risk losing both the patient and the patient's family.

In the Brooklyn VA Medical Center Alcoholism Rehabilitation Unit's family therapy program, it is assumed that the patient has already become involved in the center's resident or outpatient program, thereby addressing his or her drinking behavior and lifestyle, and is sincerely motivated to change. It is also assumed that, while the patient's drinking has influenced family life, in most cases the drinking serves as a smoke screen for serious communication deficiencies. These are the focus of therapy.

The patient and the patient's family are informed of these assumptions early in treatment and therefore are made aware that it is the family structure that is the patient, not the family member who has alcoholism. Accordingly, we will not entertain any "horror stories" involving the patient's drinking behavior in our sessions. However, the center offers a family "rap" group in which such material is both expected and welcome for discussion This enables the family therapist to channel concerns about alcoholism-related behavior to an appropriate source, and clears the way for the family to focus on material that does not involve alcohol or alcoholism.

Therapeutic Process

Generally, it is the alcoholic's spouse who is involved in family treatment, although children may also be included. Four phases are encountered during the course of family therapy, leading to the development of a solid working relationship among the therapist and family members.

- *Random Phase.* During early sessions the "naive" family acts in a relatively unstructured manner.
- *Recrimination Phase.* The family makes accusations, and attempts to engage the therapist in discussion of "what he did when he drank."
- *Policing Phase.* Family members test the boundaries of the therapist's instructions to omit references to alcohol.
- *Therapeutic Realization Phase.* A solid working alliance is built between the therapist and the patient. The patient and family begin to communicate more effectively and without reference to drinking and alcohol. At this point optimism is greatest, and patients vocalize their feelings of rapport with the therapist.

Following are discussions of two specific cases involving couples who benefited from this specialized family therapy, with discussion of how the therapist dealt with each phase of the therapeutic process.

Mr. and Mrs. B were seen once a week for 2 years. Mr. B, the identified patient, was a 48-year-old foreman at a brewing company with 28 years of steady employment on the same job. Mrs. B had been employed more than 20 years by the local transit authority. Both Bs had been married previously, Mrs. B to an alcoholic, and they had two children each from past marriages. They had been married for 2 years before beginning marital treatment following Mr. B's completion of the center's 6-week inpatient program. Mr. B had been drinking since he was 13 years old and had been diagnosed as alcoholic. The residential treatment was uneventful, and he was abstinent at discharge.

Random Phase. The presenting treatment problem in the family session was Mrs. B's distrust of Mr. B's ability to remain sober. Initially, there was considerable hostility between Mr. and Mrs. B, and it increased as each reacted by counter-attacking the other. They made virtually no independent attempts to communicate their problems to each other, and both denied the existence of conflicts other than those they presented in their initial session: Mrs. B feared that Mr. B would return to drinking, while Mr. B resented Mrs. B's sexual and emotional coldness towards him and her "over-involvement" with her 19-year-old son and invalid father, who were living with them.

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Recrimination Phase. The Bs were allowed virtual freedom in structuring the first two sessions themselves, resulting in a continuous stream of accusations and counter-accusations about his behavior when he drank and her rejecting behavior towards him. At this point, therapeutic intervention was initiated. Mrs. B was assigned to a family "rap" group that met at the same time as Mr. B's alcoholism outpatient group, and the couple was told that Mr. B's drinking condition would be discussed in the other group but not during family counseling time. The Bs also were told that the therapists thought the problems they reported were masking other, underlying communication problems between them, and that these problems would be the focus of subsequent counseling sessions.

Policing Phase. During the next 2 months, the therapists enlisted the aid of the patients in identifying recriminatory content in sessions. With this teamwork approach, the rate of recrimination soon dropped to near zero and ceased during the next phase of treatment. The Bs were cooperating successfully with attempts to focus therapeutic attention on underlying communication problems rather than on alcohol-related problems.

Therapeutic Realization Phase. In the third month of therapy, the patients and the therapist worked together to change the communication patterns of Mr. B, who would

fall silent rather than express his dissatisfaction to his wife, and those of Mrs. B, who had been turning away from her husband as an expression of her resentment. They learned to express their grievances, and at the end of this period, were able to gratify each other's needs from time to time. Furthermore, they developed a new common bond—shared recreational activities. At this point, it was agreed by the therapists and patients that regular sessions were no longer crucial. Followup 2 years later indicated that the patients were still communicating successfully. A 4-year followup revealed continuing success.

Another couple, Mr. and Mrs. M, were seen weekly for 8 months. Mr. M was a 43-year-old former delivery-truck driver with a reliable work history. Mrs. M, 39 years old, had done clerical work in the past but had not worked for 12 years, preferring to stay at home and raise the couple's two children, now teenagers. The Ms had been married 20 years. Marital therapy was begun after Mr. M's completion of the center's 6-week inpatient program. His drinking history dated from his teenage years, and he had been diagnosed as having chronic alcoholism. Inpatient treatment was uneventful and successful.

In the family counseling session, the Ms differed on the presenting problem. Mrs. M distrusted her husband's ability to remain sober. For Mr. M, this mistrust was a problem, but his main complaint was her hostility and unwillingness (or inability) to be affectionate and to solve problems together. Mrs. M had in the past 14 months been a member of a weekly therapy group at another facility, and she was continuing these sessions simultaneously with those at the center.

Random Phase. Although both the Ms were hostile in the initial phase, Mr. M demonstrated considerably greater ego strength than did Mrs. M, who seemed to deteriorate emotionally as rapidly as her husband progressed. Mr. M appeared willing to discuss problems openly, in an attempt to resolve differences, and was eager to understand the psychological mechanisms operating to cause their problems. Mrs. M seemed threatened by this sort of discussion. She acquiesced passively to attempts to discuss the issues, but gave no indication that she understood the underlying relationship problems. Mr. M responded angrily to this frustrating acquiescence by his wife, generating mutual hostility.

In an apparent case of the overadequate - underadequate relationship often described by family theorists, the husband's alcoholism in the past had masked his wife's inadequate personality and a stable, albeit precarious, balance had been maintained between them while he was drinking.

Recrimination Phase. Mr. and Mrs. M continuously criticized and berated each other in the early sessions. Mrs. M was given specific instructions to use her own therapy group in a manner similar to the way the center's "rap" group had functioned. The Ms were told that counseling would be based on the assumption that underlying communication differences existed between them that had previously been masked by Mr. M's alcoholism and drinking behavior. The Ms also were told that the therapists assumed Mr. M was sincere in his motivation to quit drinking, and that sessions would focus entirely on their communication problems, leaving his alcoholism to be treated in another part of the program, in which he was active.

Policing Phase. In the next month, recriminatory attitudes in the patients' dialogue were pointed out as they occurred, and the rate of recriminations dropped to zero by the end of the month. Although Mrs. M's own problems had been masked by Mr. M's alcohol problems, the fact that she had been in her own independent treatment for over a year prior to our sessions gave the couple a head start in resolving some of their marital differences. Mr. M was thereby able to understand that his wife's difficulties were independent of his own, and he stopped playing the "heavy" in the marriage. When Mrs. M saw her husband's behavior change, she stopped denigrating him and began to express appreciation for his strengths.

When the Ms left treatment at the end of 8 months, they both were expressing affection for each other. They resumed a sex life and began to handle family problems as a team. Followup after 4 years showed these gains to be permanent.

Discussion

The case material presented here illustrates the need for and the effectiveness of a specialized approach to counseling the alcoholism family, based on principles of family therapy. The key to this approach is to isolate discussion of the patient's alcoholism and related behaviors during marital or family therapy sessions, thus eliminating many potential complications of therapy. The alcoholism is treated in separate counseling groups that family members attend. This frees the couple to deal with underlying communication problems.

Advantages of A Computer-Based Treatment Plan In An Alcoholism Treatment Program

John D. Lovern, Ph.D., and Joseph Zohn, Ph.D.

In 1972, the Joint Commission on Accreditation of Hospitals (JCAH) initiated the requirement that psychiatric facilities develop individualized treatment plans for all their patients. Soon afterward, alcoholism and drug treatment programs were required to develop similar treatment plans. These requirements have become more demanding over time, asking for increasingly detailed and comprehensive plans. Clinicians who work in psychiatric, drug, or alcoholism programs must somehow achieve two objectives that compete for their time: to provide quality patient care and to satisfy the ever-increasing requirements for documentation. Caregivers, whose primary mission is to treat patients, are finding themselves spending more and more time writing about what they have less and less time to do. Those who try to minimize the time they spend on treatment plans face the likelihood of producing documents that are overly simplistic or vague and that do not accurately reflect what they are doing for their patients.

A need exists for a method that can enable clinicians and treatment teams to devise treatment plans to satisfy JCAH requirements and still leave time to provide the needed treatment. Such a method, developed in the hospital-based alcoholism treatment program in operation at the Alcohol Dependence Treatment Program of the Jerry L. Pettis Memorial Veterans Administration Hospital in Loma Linda (California), appears capable of accomplishing both of these objectives. While computerized treatment planning is not a panacea, it can be a significant aid to program staff. This method reduces the time needed to devise a treatment plan to only 10 or 15 minutes; plans developed with this approach routinely meet or exceed JCAH requirements for individualized, comprehensive treatment plans; and regular documentation of patient progress (the recurring part of treatment planning) is streamlined as well, resulting in additional economy of time and quality of content. In addition, the method contributes to, and reinforces, a unified treatment philosophy among all staff. Many readers may initially be skeptical. However, after 2 years of experience, this method has been shown to be effective in our setting.

This method was developed as a noncomputer, pencil and paper checklist that can easily be transferred to computer; in either form it considerably reduces the time alcohol program staff spends devising treatment plans (Lovern and Zohn 1980). Perhaps the most convincing support for this approach is demonstrated by the fact that the JCAH awarded a 1-year accreditation to the entire hospital while the Alcohol Dependence Treatment Program was singled out and awarded a 2-year accreditation. The Joint Commission's reviewers cited the quality of the treatment care plans and documentation of progress as a principal factor in their favorable evaluation.

Method

At the heart of the computer-assisted method is a dictionary that lists patient strengths and problems, therapeutic goals and intervention methods, and other key information useful in formation of a treatment plan. These factors are catalogued and stored within the computer. The dictionary is accessible via hierarchical branching, keyword, synonym, or direct access. Dictionary entries may be linked together in the cases of commonly associated problems, goals, and interventions. Free-text modifiers allow more specification, and this is the key to individualization of treatment plans. The system's hardware is a user-interactive minicomputer that uses American National Standards MUMPS language. This particular language was preferred because it facilitates user-computer interaction with minimal staff training.

The headings used in the dictionary conform to the "fundamental needs" listed by the Joint Commission. We have taken the 11 need areas specified in the most recent standards (JCAH 1979), eliminated those that are irrelevant (such as

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"developmental," which related to children and does not apply to our all adult population), and consolidated the list so that there are 4 fundamental need areas, including subareas Step-by-step progression through these areas ensures that a treatment planner addresses every relevant JCAH need area. In addition to prewritten items, there are opportunities to add free-text terms, modifiers, or listings of strengths, problems, and goals to aid in individualization of treatment plans.

The clinician who is primarily responsible for devising the treatment plan reviews the patient's chart, interviews the patient for supplemental information, and then selects appropriate content items that are displayed on the computer terminal screen. The completed treatment plan usually includes patient demographic data; names of staff present at the treatment planning conference; patient strengths; patient problems; treatment goals and methods; discharge criteria/projected discharge data; planned residence and source(s) of financial support; plans for followup treatment; job readiness criteria (physical and psychological); a statement that the patient participated in plan development and concurs with the plan; and the signature of the case manager and the next review date (See Demonstration Plan).

The system is most useful in the identification of treatment methods and goals for individual patients. The clinician first identifies a problem in one patient need area—physical, psychological, social, or vocational-recreational—and is presented with one or, at most, two or three appropriate treatment goals. After a goal is chosen, a method or choice of methods for achieving the goal is similarily selected. The provider of services and time needed to complete the goal(s) are specified.

It was thought undesirable to create overwhelmingly long lists of possible items (and even longer lists of possible combinations) that treatment planners would have to review each time they devise a plan. While it involves some compromise to individualization, one way to avoid this outcome is to create a one-to-one relationship between the problems that are identified and the goals and methods that are associated with each problem. Items are conceived carefully so that, whenever possible, there is only one goal and intervention method for each problem. Occasionally it is necessary to list two or three goals and methods for any given problem, but this is the exception rather than the rule.

Additional problems are addressed in the same manner, and step-by-step progression through each of the four need areas ensures that no one area is missed. Treatment plans can be further individualized by adding free-text modifiers. The computer stores the completed plan for presentation at a treatment planning conference. After the conference, a final team-approved version is printed, signed, and placed on the chart where it serves as a guide for periodic review.

The greatest challenge to the planner lies in writing the items. Problems must be defined so that goals and methods logically follow from the definitions, and methods that all the staff can agree on must be chosen. Care also needs to be taken to phrase problems and goals in terms of concrete behaviors of the patients, and methods used should relate specifically to these observable behaviors without being so specific that they cannot be generalized to a number of situations. Goals should be carefully worded, so that the criteria for measuring progress are implicitly clear.

Use of behavioral terms enables the planner to conceptualize, discuss, and write about patient progress in a simple, clear, and reliable manner, so progress notations and treatment plan reviews become easier and less time consuming. As treatment planners become increasingly familiar with the items used, they find it easier to think about patients in terms of treatment plan concepts. This contributes to an overall agreement by program staff regarding patients and their needs, and as a result, the program is guided by a more unified treatment philosophy.

Many other advantages accrue from using a computerized treatment planning system. Information about each patient can be stored in the computer's memory, which simplifies auditing of patient records. Many kinds of research are facilitated as well, such as the investigation of how treatment approaches relate to outcomes or how patient problem variables relate to prognoses.

The computer can also remind clinicians when a review note is due, keep track of planned treatments, remind staff to perform treatment tasks in a timely manner, require clinicians to justify a patient's extended stay in the hospital, and summarize patient status with regard to achievement of planned treatment goals. Currently, the authors are also investigating ways to use the computer to assist clinicians in writing progress notes, patient histories, and intake and discharge summaries.

References

Joint Commission on Accreditation of Hospitals. *Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs.* Chicago: JCAH, 1979.

Lovern, J.D., and Zohn, J. "Preliminary Report on the Usefulness of a Computerizable Treatment Plan Checklist in a Hospital-based Alcoholism Treatment Program." Paper presented at the California State Psychological Association meeting, Pasadena, February 1980.

Demonstration Treatment Plan

DATE PLAN APPROVED BY TEAM: T+7 days

NAME: John Doe

Patient Information:
Age: 49
Date of Birth: 3/11/31
Sex: Male
Marital Status: Married, for 5 years
Education: 12 years
Employment Status: Unemployed
Occupation: Bricklayer
Ethnicity: Irish-German
Religion: Catholic
Housing Prior to Admission: Mobile home, owned by patient, in San Bernadino, CA
Lived With: Wife, 3 step-children
Service-connected Status: Non-service-connected
Presenting Complaint: Alcoholism

Staff Attending Treatment Planning Conference:
Sally Smith, M.D., Psychiatric Resident Physician
George Jones, Ph.D., Psychologist
Ken Nelson, Ed.D., Counseling Psychologist
Mike Brown, M.S.W., Social Worker
Alice Johnson, R.N., Nurse

NOTE: While the demonstration plan does not contain the entire dictionary of items because of space limitations these can be obtained by contacting the author. This example is not a complete plan and is intended only as an example; in actual practice, a greater number of problems would be listed. All names used are fictional.

Team Contact Person/Case Manager: George Jones, Ph.D. (Psychologist)

Strengths:
Physical:
Within ideal weight range
Nonsmoker
Psychological:
Absence of serious psychopathology
Memory is intact
Optimistic, hopeful
Social:
Intact family
Spouse willing to participate in treatment
Stable residence
Wife works, has income
Lives near enough to participate in daily program
Has operator's license
Owns a reliable vehicle with insurance
Vocational:
Has salable job skills

Problems/Goals/Plans:
Problem: (Physical) Possible alcohol-related vitamin deficiency
Goal: Insure sufficient vitamins
Method: Vitamin regimen
Provider: Sally Smith, M.D. (Physician), Nursing staff
Time Frame: T+35 days

Problem: (Physical) Underweight, undernourished
Goal: Insure adequate nutrition
Method: Regular diet, with supplements
Provider: Sally Smith, M.D. (Physician)
Mary White, R.D. (Dietitian)
Time Frame: T+35 days

Problem: (Psychological) Mental mismanagement, manifested by frequent or consistent avoidance of commitment, responsibility, or decisions; bases important decisions on momentary wants or whims, instead of using principles to guide behavior
Goal: More competent self-management and corresponding increase in self-esteem and sense of mastery
Method: Practice in planning and receiving feedback on effectiveness; encourage development of adaptive resources to deal with stress. In group therapy and patient government
Provider: George Jones, Ph.D. (Psychologist), Nursing staff
Time Frame: T+35 days

Problem: (Psychological) Strong psychological dependence on alcohol, manifested by drinking to reduce shyness and self-consciousness and drinking to fit in with peer group
Goal: Development of alternate, adaptive dependencies: Learn to rely on people, sobriety-supporting groups for relief or support
Method: Exposure to supportive group atmosphere, Alcoholics Anonymous, patient government, group therapy
Provider: George Jones, Ph.D. (Psychologist), Nursing staff
Time Frame: T+35 days

Problem: (Psychological) Resistance to alcoholism treatment, manifested by compliance: Seems or pretends to be responding favorably to treatment, while actually harboring resistance
Goal: Thoroughgoing acceptance of need for treatment and wholehearted participation in treatment (surrender)
Method: Consistent refusal to accept or approve halfway measures in all groups and patient-staff interactions
Provider: George Jones, Ph.D. (Psychologist), Nursing staff
Time Frame: T+35 days

Problem: (Social) Patient may be in treatment primarily to influence a legal decision—desired outcome is to avoid violation of probation
Goal: Force patient to decide which is really more important—legal matter or recovery from alcoholism
Method: Encourage forthrightness; point out inconsistencies in talk and behavior. In group therapy and patient government
Provider: George Jones, Ph.D. (Psychologist), Nursing staff, Mike Brown, M.S.W. (Social Worker)
Time Frame: T+35 days

Problem: (Social) Significant others adversely affected by alcoholism and in need of treatment for their own problems. Who: wife and step-children
Goal: Significant others discover they have problems, come to focus on these instead of patient's problems, attend Al-Anon, Alateen
Method: Encourage significant others to recognize problems by educating them, shocking them, inducing confusion, and restructuring their views, then encouraging Al-Anon/Alateen attendance. Family therapy
Provider: Mike Brown, M.S.W. (Social Worker), George Jones, Ph.D., (Psychologist), Nursing staff
Time Frame: T+35 days

Problem: (Social) Relationship with significant other(s) disrupted; many important issues unresolved. Relationship disrupted by manipulation, dishonest communication, secrets, avoidance of important issues in the relationship
Goal: Patient and significant other(s) develop mutual understanding and begin to communicate forthrightly about unresolved issues
Method: Begin teaching basic communication skills in family therapy
Provider: George Jones, Ph.D. (Psychologist), Nursing staff, Mike Brown, M.S.W. (Social Worker)
Time Frame: T+35 days

Problem: (Social) Misconceptions of significant other(s) about alcoholism are threat to patient's recovery. Faulty beliefs include belief that alcoholism is moral weakness or sin
Goal: Significant other(s) accept alcoholism as serious disease requiring extreme commitment by both them and the patient
Method: Encourage significant other(s) to recognize problems by educating them, shocking them, inducing confusion, and restructuring their views, then encouraging Al-Anon/Alateen attendance. Family therapy
Provider: George Jones, Ph.D. (Psychologist), Nursing staff, Mike Brown, M.S.W. (Social Worker)
Time Frame: T+35 days

Problem: (Cultural) Background and upbringing cause patient to have values and behavior that conflict with recovery, including belief that a "real man" should be able to drink
Goal: Patient become aware of interfering values and incorporate new values supportive of recovery
Method: Bring patient to awareness of values and their effects on recovery. Group therapy and patient government
Provider: George Jones, Ph.D. (Psychologist), Nursing staff
Time Frame: T+35 days

Problem: (Cultural) Religious upbringing causes patient to have values and feelings that conflict with recovery; for example, strong feelings of guilt
Goal: Patient become aware of interfering values and incorporate new values supportive of recovery
Method: Bring patient to awareness of values and their effects on recovery. Group therapy and patient government
Provider: George Jones, Ph.D. (Psychologist), Nursing staff
Time Frame: T+35 days

Problem: (Vocational-Recreational) Unemployed
Goal: Patient develop realistic plan for gradual return to work, which will not interfere with recovery
Method: Patient formulate a Discharge Plan with special attention to this problem, then present it to patients and staff for feedback and revision. Group therapy. Referral to counseling psychologist for prevocational counseling to aid patient in formulating return-to-work plans
Provider: George Jones, Ph.D. (Psychologist), Nursing staff, Ken Nelson, Ed.D. (Counseling Psychologist), Mike Brown, M.S.W. (Social Worker)
Time Frame: T+35 days

Problem: (Vocational-Recreational) Work setting subjects patient to pressure to drink in the following way(s): There is social pressure among co-workers to drink, and drinking on job is commonplace
Goal: Patient develop plan for changing work settings or own approach to present work setting
Method: Patient formulate a Discharge Plan with special attention to this problem, then present it to patients and staff for feedback and revision. Group therapy. Prevocational counseling, provided by counseling psychologist, to guide patient in planning whether and/or how to change the work situation, occupation, etc.
Provider: George Jones, Ph.D. (Psychologist), Nursing staff, Ken Nelson, Ed.D. (Counseling Psychologist), Mike Brown, M.S.W. (Social Worker)
Time Frame: T+35 days

Problem: (Vocational-Recreational) Unrealistic, maladaptive expectations about work, including placing overly high priority on getting back to work; could sacrifice treatment in favor of job
Goal: Develop realistic adaptive expectations about work
Method: Patient formulate a Discharge Plan, with special attention to this problem, then present it to patients and staff for feedback and revision. Group therapy. Referral to counseling psychologist for prevocational counseling to aid patient in formulating return-to-work plans
Provider: George Jones, Ph.D. (Psychologist), Nursing staff, Ken Nelson, Ed.D. (Counseling Psychologist), Mike Brown, M.S.W. (Social Worker)
Time Frame: T+35 days

Problem: (Vocational-Recreational) Does not know how to entertain or amuse self
Goal: Develop resources for entertaining self, such as a hobby
Method: Patient formulate a Discharge Plan, with special attention to this problem, then present it to patients and staff for feedback and revision. Patient should be encouraged to develop a hobby or interest to pursue
Provider: George Jones, Ph.D. (Psychologist), Nursing staff
Time Frame: T+35 days

Discharge Criteria (Conditions under which patient may be discharged):

Completion of minimum 35-day program; Discharge Plan with realistic arrangements made for housing, finances, and followup treatment, which will be supportive of recovery, and that patient is likely to carry out; sufficient emotional and psychological stability at time of discharge so that patient is judged unlikely to drink or otherwise behave rashly in a way that could threaten recovery. Projected Discharge Date: T+35 days

Job Readiness Criteria (Conditions under which patient will be deemed ready to return to work):

Physical: Continued sound physical condition

Psychological: Realistic expectations about work (i.e., not believing that work will make patient normal or "cured"). Adaptive priorities about work (i.e., not placing work ahead of recovery effort). Should return to work gradually and with support and guidance of peer treatment group

Planned Aftercare, Followup:

Residence and Support:
Patient should live at: Home with family. Who: wife and step-children. Patient will support self with: Savings. State Disability Insurance. Family income (spouse is a wage earner)

Followup Care:
Outpatient ADTP. Alcoholics Anonymous. Al-Anon/Alateen for family members

Patient's Response To Treatment Plan:

Staff member attests that patient participated in devising the plan and discussed the plan with a staff member (when signed below).

Patient's Reaction: Concurs with entire plan

Projected Review Date: Once a week (each Tuesday)

Signature Of Case Manager:

T+7 Days	George Jones, Ph.D.	Psychologist
Date	Name and Degree	Functional Title

RESEARCH REPORTS

Alcohol and the Cardiovascular System

The relationship between alcohol use and cardiovascular disease has posed something of a dilemma for those in the alcohol field, Charles Kaelber, M.D., Dr. P.H., said at a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) Epidemiology Seminar.

While the occurrence of some cardiovascular diseases—alcoholic cardiomyopathy and hypertension, for example—has been associated with heavy alcohol use, several studies have also shown that moderate consumers of alcohol appear to have a lower coronary heart disease rate than those who abstain, said Kaelber, who is chief of NIAAA's Laboratory of Epidemiology and Population Studies. "We may have to live with a certain amount of ambiguity, because there's no reason to expect alcohol to have a single effect on the heart and blood vessels," Kaelber said.

According to Kaelber, alcohol has not one but multiple sites of action within the cardiovascular system, and thus may affect different cells in different ways. Abundant evidence suggests that alcohol acts directly on the heart muscle as well as on the coronary arteries and on the central and peripheral nervous systems which influence cardiovascular function, he said. Evidence also suggests that the acute or short-term effects of drinking may differ from the chronic effects of long-term drinking in which biochemical changes lead to structural damage.

In addition, he said, alcohol's effects are dose dependent, with higher doses possibly exerting effects quite different from those of lower doses. Finally, alcohol's effect on the heart may vary depending on other factors that cause individuals to react differently.

In discussing cardiovascular diseases associated with the use of alcohol, Kaelber said that alcoholic cardiomyopathy or enlargement of the heart was recognized as a distinct entity and included in the international classification of diseases in 1979. However, it had first been identified more than 100 years earlier among beer drinkers of Munich, Germany. Initially dubbed the "Munich beer heart," it gradually became clear that the condition was specific nether to Munich nor to beer drinking.

Cardiomyopathies in the early stages can be detected by EKG changes, Kaelber said. As the heart chambers and muscle mass slowly and insidiously enlarge, the heart's effectiveness as a pump decreases. Eventually, death occurs commonly from congestive heart failure.

The diagnosis is made by exclusion of other causes of cardiomyopathy. One looks for other possible causes of enlargement, and then considers alcohol if there is a history of heavy drinking. A persistent notion since the turn of the century has been that a specific substance or toxin in beer or alcohol might be responsible although one has never been found, Kaelber said. Also, in the early 1920s, a thiamine deficiency was suspected as a cause of heart enlargement, since thiamine administration helped some patients. In the 1950s and 1960s it became clear that thiamine deficienct cardiomyopathy and alcoholic cardiomyopathy were two distinct entities. Alcoholic cardiomyopathy is not common even among heavy drinkers, Kaelber said, and those who do develop it typically do not develop liver cirrhosis, and vice versa.

The relationship between alcohol and hypertension surfaced in epidemiologic cardiovascular disease studies of the 1950s, Kaelber said. One of these studies involved men working for the Chicago Western Electric Company. In 1957-58, these men were given a free medical exam after which their health status was followed for several years. The incidence of hypertension increased among the men as their average daily alcohol intake went up, Kaelber said. Twenty percent of those who abstained were defined as hypertensive, while 26.9 percent of those who drank two to three drinks daily were hypertensive, and 47.4 percent of those who had six or more drinks daily were hypertensive.

Other studies confirmed the association between drinking and hypertension, although there was some indication that persons who drank small amounts of alcohol—one to

three drinks daily—had lower blood pressure than those who abstained altogether.

What remains unclear from these early studies is whether high blood pressure precedes heavier alcohol use or vice versa. It is also possible that no casual relationship exists—that other factors such as stress, for example, may contribute to both attributes. Nonetheless, the recommendation of most clinicians at this time is for hypertensive persons to moderate alcohol consumption for a variety of reasons, including, for example, to control weight, Kaelber said.

Atherosclerosis, or the clogging of the arteries with cholesterol and other fat deposits, also has been linked to alcohol consumption, although study findings are not all consistent. Manifestations of atherosclerosis include chest pain and heart attack; sudden death can result.

Angina pectoris, or chest pain, was first described more than 200 years ago. At that time, the taking of alcohol was recommended as a form of treatment because of its painkilling effect. This was discontinued, though, since pain was later seen as a warning to the patient to stop exertion. Today, nitroglycerine is taken to increase the blood flow to the heart and reduce anginal pain.

In discussing the possible protective effects of alcohol use, Kaelber said that in the late 1950s it was observed that moderate consumers of alcohol appeared to have a lower coronary heart disease mortality rate than those who abstained. The Honolulu Heart Study, report in 1980, confirmed these findings. Hawaiians of Japanese descent who consumed at least 40 ounces of alcohol monthly had the lowest coronary heart disease rate of those studied. However, the risk for other complications such as liver cirrhosis and cancer increased with increasing alcohol consumption, Kaelber said.

In the Chicago Western Electric Company study, the risk of heart disease decreased with moderate alcohol consumption; those who had four to five drinks daily had the lowest age-adjusted death rate for coronary heart disease. "This supports the findings that alcohol in modest doses is not harmful," Kaelber said. For those who drink six or more drinks daily, however, the opposite findings prevailed—the risk of death from all causes, including coronary heart disease, increased substantially.

Other studies also have confirmed the association between a low death rate for coronary heart disease and moderate drinking, he said. The effect appears to be related to alcohol's elevation of HDL (high density lipoprotein) cholesterol, the "good" cholesterol associated with low levels of coronary heart disease. LDL (low density lipoprotein) cholesterol, normally present in greater amounts in the body than HDL cholesterol, has been associated with higher mortality.

Because this is such an important public health issue with various implications for prevention, further research studies are needed to help clarify the effects of alcohol on the cardiovascular system, Kaelber concluded. For further information, contact Charles T. Kaelber, M.D., Dr. P.H., Laboratory of Epidemiology and Population Studies, NIAAA, Room 16C16, 5600 Fishers Ln., Rockville, MD 20857.

The NIAAA Divisions of Research, in collaboration with the Epidemiology Council of the American Heart Association, recently published the *Proceedings of a Symposium on Alcohol and Cardiovascular Diseases* as a supplement to *Circulation*, Part II, Vol. 64, No. 3, 1981. Single copies of the *Proceedings* are available free from NCALI, P.O. Box 2345, Rockville, MD 20852. Please request PH174.

Nancy Johnson, NCALI

STIARS Available

A series of publications available from the National Clearinghouse for Alcohol Information provide translations of selected research articles published in foreign countries. Among recent articles issued in the STIAR (Selected Translations of International Alcoholism Research) series are the following:

- STIAR 34: "Cirrhosis of the Liver and Pregnancy: A Review of Five Case Histories," by G. Crepin, D. Querleu, C. Bigant, G. Delahousse, J. Decocq, M. Delcroix, and F. Caquant, translated from French.
- STIAR 61: "Embryofetal Alcohol Syndrome: Followup of a Family," by F. Fitze, A. Spahr, and G. Pescia, translated from German.
- STIAR 63: "Assessment of Recovery From Organic Brain Syndrome in Chronic Alcoholics Using the Benton Test," by M. Krampe, translated from German.
- STIAR 66: "Effects of Prolonged Administration of Large Doses of Alcohol on Blood Circulation in Rats," by V. Morvai and Gy. Ungvary, translated from Hungarian.
- STIAR 68: "The Effects of Alcohol on Progeny," by A.M. Skosyreva, translated from Russian.

Single copies of STIARS are available, free of charge, from the National Clearinghouse for Alcohol Information, P.O. Box

2345, Rockville, Maryland 20852.

Jill Vejnoska, NCALI

Effects of Family History of Alcoholism

Young men who have a family history of alcoholism appear to react very differently to three or four drinks of alcohol than do young men without a family history of alcoholism, according to Marc A. Schuckit, director of research of the alcohol treatment program at the Veterans Administration Medical Center in San Diego, California.

According to Schuckit, who spoke at a recent NIAAA epidemiology seminar, men from an alcoholic family report feeling less intoxicated, and a variety of scientific tests confirm that their physical and mental abilities are less impaired. Moreover, Schuckit said, their bodies apparently produce much higher levels of acetaldehyde, a chemical byproduct of the breakdown of alcohol that has been associated with body organ damage.

Schuckit speculates that those men with a family history of alcoholism may be less sensitive than other men to low doses. This may mean, he says, that "they have less warning that they are becoming intoxicated but indeed in the end become quite intoxicated." Previous research has indicated that genetics play at least a partial role in the development of alcoholism and some studies have shown that sons of alcoholics have a four to five times greater than normal risk of developing alcohol problems.

Schuckit's research was designed to study the presumably inherited differences between those at high and at low risk for alcoholism and to determine whether these differences predispose the high risk group to future drinking problems. "That is," Schuckit said, "on any given evening when drinking, are there differences between people at higher risk and at lower risk in how those first few drinks affect them?"

The high risk participants in the studies included nonalcoholic students and nonacademic staff members 21 to 25 years old who had a first-degree relative—parent or sibling—who was alcoholic. A questionnaire eliminated problem drinkers and drug abusers from the study group. Then statistics on demography, height/weight ratio, and drinking history were used to select matching control groups of men without a family history of problem drinking.

Breathalyzer and blood alcohol measures were taken before the men consumed the equivalent of three to four drinks (.75 ml kg body weight of 95 percent ethanol). The tests were repeated after consumption at 15, 30, and 60 minutes, and every 30 minutes thereafter. Other measures of intoxication were obtained as well; in one test designed to measure intoxication, subjects were asked to indicate how intoxicated they felt by ranking statements associated with intoxication, such as "I feel dizzy" or "I feel nauseated," on a scale from 1 to 10.

The two groups differed on about half of the 55 items, and repetition of the study with a more sophisticated scale showed a difference on 56 percent of the items. The men without any family history of alcoholism appeared to feel more intoxicated than those with a family history of drinking problems, Schuckit said.

Because self-reported data is subject to bias, the investigators later conducted other tests of intoxication. For example, in the pursuit rotor test, the men without a family history of alcoholism made more errors while trying to hold a stylus on an off-center dot as a record turntable rotated. In tests of reaction and movement time, the results were similar. The person sat at a board with a display of buttons and corresponding lights. The index finger was placed on one button, and when another light went off, the person lifted his finger (reaction time) and moved to depress the button corresponding to the other light (movement time). In general, more errors were made by those without a family history of alcoholism.

In cognitive tests of mental abilities the trend was in the same direction. "In fact, I believe that, in every test we've done to date, if there was a difference (and on most tests there was), if there was a trend, it was for the family-history-negatives to show more performance impairment," Schuckit said.

The investigators also looked for changes within the body and found that levels of the hormones cortisol and prolactin were significantly higher after alcohol consumption among those with no family history of alcoholism. Measures of brain waves in five pairs of young men also indicated significant differences between the two groups.

In another of their recent studies, the researchers found that men with a family history of alcoholism appear to form about twice as much acetaldehyde as do men without a family history of alcoholism. Some studies have indicated that acetaldehyde may combine with other substances in the brain to form substances similar to morphine, a drug well-known for its painkilling and addictive properties. High levels of acetaldehyde also are associ-

ated with body organ damage. "The importance of this is that a higher acetaldehyde level could theoretically change the quality of the "high" or tolerance; at the very least, if the acetaldehyde level was higher in the family history positives than in the negatives, it could increase their risk for organ damage—brain, liver, or heart damage," Schuckit said.

The findings of the studies are tentative, Schuckit cautioned, because often only small numbers of subjects were involved, and in some of the studies placebo controls were lacking. Replication is needed, and there is also a need for further investigation of differences between high and low risk groups at higher doses of alcohol.

Nonetheless, the data are "consistent with the possibility that the two groups appear to differ in their mode of metabolism of alcohol," Schuckit said. "We used similar methods in groups, and there has been a trend, frequently a statistically significant difference of magnitude worth noting, for the family-history-negative individual to react to alcohol with greater intensity than the family-history-positive." For further information, contact Marc A. Schuckit, M.D., VA Medical Center, Mail Code 116(A), 3350 La Jolla Village Drive, San Diego, California 92161.

Nancy Johnson, NCALI

Moderate Drinkers Suffer Intellectual Impairment

Light and moderate social drinkers appear to experience a loss of some intellectual abilities, even when sober, as a result of their drinking, Elizabeth S. Parker, Ph.D., said at a recent NIAAA epidemiology seminar. The degree of impairment appears directly related to the amount the drinker usually consumes each time he or she drinks, but frequency of drinking does not appear important, said Parker, a research psychologist at the laboratory of clinical studies at NIAAA.

Parker's findings, based on a survey of Detroit workers, indicate that while the effects appear to diminish as consumption does, in a dose-response manner, they are still measurable at very low nonalcoholic levels. "We are not saying people are in the clinically impaired range, but that the subtle loss in cognitive powers could significantly interfere with everyday functioning, particularly among those involved in intellectual activities," she said.

In the Detroit study, a representative sample of 1,365 male and female employees were asked about their drinking practices. The employees also were given tests of cognitive functioning to measure a variety of mental abilities. The male respondents reported drinking an average of 1.3 ounces of absolute alcohol (two to three drinks) on a typical drinking occasion, 2.9 times per week. The female respondents reported drinking an average of 1.0 ounces about 1.6 times per week. As reported drinking per occasion increased, the men showed a steady decline in abstraction ability on the tests they took. Abstraction is the high-order cognitive ability that allows one to see what is common or universal in things; the ability to complete a sequence (up-down, north-. . .), for example, is dependent on abstraction abilities. However, the researchers found, the amount the men drank had no effect on old or acquired knowledge tested, such as understanding the meaning of words.

The women in the group who drank less than once a week experienced no effects, but those who drank more than once a week followed the same general pattern as the men; there was increasing deterioration of abstraction abilities as more drinking per occasion was reported. This indicates there may be a certain threshold frequency, or a necessary minimum number of drinking times per week before mental abilities begin to be affected, Parker said.

These findings confirm findings of an earlier study by Parker of a homogeneous population of upper-middle-class California men. Findings were also similar in another study Parker completed on 22- to 23-year-old university students from well-to-do families. Because people vary, it is impossible to pinpoint with any accuracy the quantity any particular individual would need to drink before being affected, Parker said, but further studies should yield additional data.

Parker's associates in the Detroit study were Douglas A. Parker, Ph.D., and Jacob A. Brody, M.D., of the Epidemiology, Demography, and Biometry Program at the National Institute on Aging in Bethesda, Maryland. For further information, contact Elizabeth S. Parker, Ph.D., Research Psychologist, Laboratory of Clinical Studies, Building 31, Room 4C34, National Institutes of Health, Bethesda, Maryland 20205.

Nancy Johnson, NCALI

FACTS FOR PLANNING NO. 2 Alcohol Use As An Indicator Of Psychoactive Drug Use Among The Nation's Senior High School Students

Cherry Lowman, Ph.D., NCALI Staff

There is a remarkable correspondence between the degree of alcohol use and extent of experience with other psychoactive drugs among senior high school students, based on recent findings from a national probability survey of students in grades 10 through 12. The survey was conducted in 1978 by the Research Triangle Institute (RTI), under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA).

In a self-administered questionnaire, students were asked about their drinking practices and their use of eight additional types of psychoactive drugs. According to these data, a linear relationship exists between prevalence of use for each type of psychoactive drug and drinking levels. Prevalence of drug use rises with each increase in students' drinking level (See figure 1 and table 1).

Highlights of Findings

- **More senior high school students use alcohol than use any other psychoactive drug.** In 1978, an estimated 75 percent of senior high school students used alcohol during the previous year—as compared with 44 percent who used some other type of psychoactive drug during the same period.

Definitions of Students' Drinking Levels

Abstainers—Don't drink, *or* drink less than once a year.

Infrequent drinkers—Drink once a month at most and drink small amounts per typical drinking occasion. Mean ounces of ethanol consumed per day by students in this category equals 0.02 oz.

Light drinkers—Drink once a month at most and drink medium amounts per typical drinking occasion, *or* drink no more than 3 to 4 times a month and drink small amounts per typical drinking occasion. Mean ounces of ethanol consumed per day by students in this category equal 0.07 oz.

Moderate drinkers—Drink at least once a week and small amounts per typical drinking occasion, *or* drink 3 to 4 times a month and medium amounts per typical drinking occasion, *or* drink no more than once a month and large amounts per typical drinking occasion. Mean ounces of ethanol consumed per day by students in this category equal 0.23 oz.

Moderate/heavier drinkers—Drink at least once a week and medium amounts per typical drinking occasion, or drink 3 to 4 times a month and large amounts per typical drinking occasion. Mean ounces of ethanol consumed per day by students in this category equal 0.72 oz.

Heavier drinkers—Drink at least once a week and large amounts per typical drinking occasion. Mean ounces of ethanol consumed per day by students in this category equal 2.32 oz.

- **In addition to alcohol, the psychoactive drugs most frequently used by senior high school students are marijuana, stimulants, cocaine, hallucinogens, and inhalants.** During the month preceding the survey, an estimated 30 percent of senior high school students used marijuana, 5 percent used stimulants, 3 percent used cocaine, 3 percent used hallucinogens, and 3 percent used inhalants (table 1).
- **Marijuana is second only to alcohol in popularity among senior high school students who reported psychoactive drug use.** Approximately 87 percent of senior high school students reported having ever used alcohol, as compared with 66 percent who reported they have ever used marijuana. An estimated 36 percent of senior high school students used alcohol in the week prior to the survey, as compared with 21 percent who used marijuana during the same period (Rachal et al. 1980*b*).
- **Most marijuana users are also alcohol users.** Only 6 percent of senior high school students who used marijuana in the year prior to the survey reported that they abstain from alcohol.
- **Marijuana use increases in extent and frequency among senior high school students who are heavier users of alcohol.** An estimated 63 per-

cent of heavier drinkers used marijuana within the previous month, compared with only 4 percent of alcohol abstainers, 9 percent of infrequent drinkers, 21 percent of light drinkers, 36 percent of moderate drinkers, and 53 percent of moderate to heavy drinkers (table 1).

- **Use of each of seven types of psychoactive drugs other than alcohol or marijuana is more extensive and more frequent among senior high school students who are heavier users of alcohol.** An estimated 16 percent of senior high school students who are heavier drinkers used stimulants in the month before the survey, in contrast to 1 percent of the students who are infrequent drinkers (table 1). An estimated 10 percent of senior high school students who are heavier drinkers used cocaine during the same 1-month period, in contrast to .3 percent of infrequent drinkers.
- **Polydrug use—the use of two or more psychoactive drugs other than alcohol—is more extensive and more frequent among senior high school students who drink more heavily.** The same strong association found between drinking levels and marijuana use also occurs between drinking levels and polydrug use. Of the heavier drinkers, 46 percent said that at some time they have used two or more psychoactive drugs other than alcohol, as compared with 5 percent of infrequent drinkers. During the month preceding the survey, 24 percent of heavier drinkers used two or more other types of psychoactive drugs, whereas only 1 percent of infrequent drinkers did.
- **From a planning perspective, awareness of alcohol use patterns among senior high school students also identifies possible use patterns of other types of psychoactive drugs. Senior high school**

Figure 1. Percentage of senior high school students who have ever used marijuana, stimulants, or cocaine by drinking level

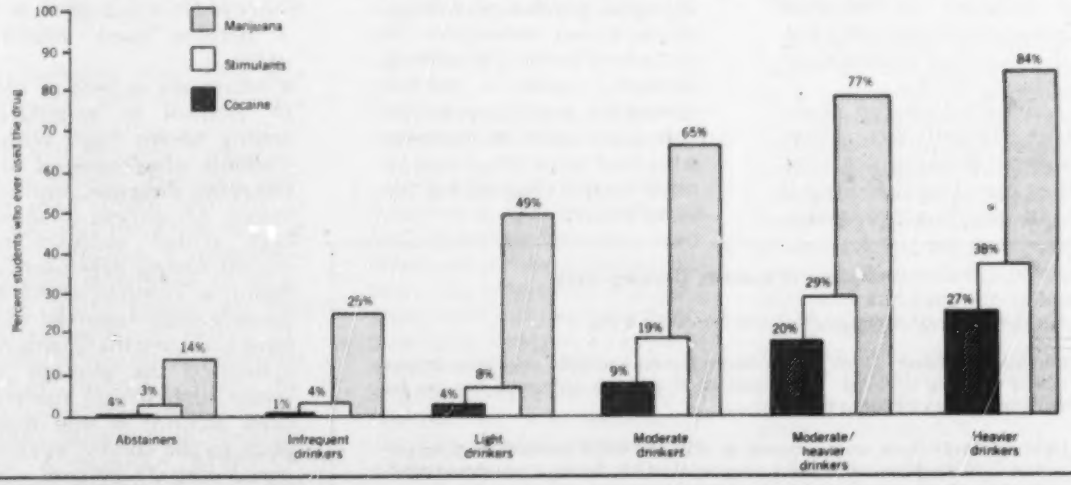

Table 1. Use of eight psychoactive drugs within the last month by drinking level (Percentage distribution)*

Drug type	Drinking level						
	Abstainers	Infrequent drinkers	Light drinkers	Moderate drinkers	Moderate/ heavier drinkers	Heavier drinkers	All students
Barbiturates	0.3	1.0	1.0	1.2	3.2	5.6	1.9
Cocaine	0.0	0.3	0.7	2.6	6.6	10.1	3.1
Hallucinogens	0.5	0.8	1.3	1.2	4.7	10.2	2.9
Heroin	0.1	0.0	0.2	0.3	0.4	1.6	0.5
Inhalants	0.7	1.3	0.9	3.5	4.2	6.5	2.7
Marijuana	3.6	8.5	20.8	35.9	52.5	62.7	29.6
Stimulants	0.3	0.7	2.3	4.5	9.4	16.1	5.1
Tranquilizers	0.3	0.5	0.7	3.2	6.0	8.4	3.0

*Percentages represent the prevalence rate for each category; for example, 5.6 percent of senior high school students who were heavier drinkers used barbiturates during the previous month.

students who are moderate to heavier drinkers are also at high risk for polydrug use. Only 7 percent of senior high school students who said they had never used alcohol had ever tried one or more of eight other types of psychoactive drugs. Approximately 74 percent of senior high school students who reported using marijuana during the year prior to the survey are moderate to heavier drinkers; 20 percent are infrequent or light drinkers; only 6 percent are alcohol abstainers. As many as 30 percent of senior high school students classified as moderate to heavier drinkers used two or more psychoactive drugs within the previous year, as compared with 7 percent of infrequent or light drinkers and 2 percent of alcohol abstainers.

Implications

Although the statistics presented in this report offer no explanation for the interdependence of alcohol and polydrug use, they do indicate that alcohol policies and programs aimed at senior high school students address a broad group, one that includes most users of other psychoactive drugs. Consequently, school- or community-based alcohol policies and programs can also reach a broad group of youth at higher risk for problems associated with the use of marijuana and other psychoactive drugs.

Theoretical analyses of the data conducted by Richard Jessor and his associates at the Institute of Behavioral Science of the University of Colorado disclose a proneness for problem behavior among alcohol "misusers" (Donovan and Jessor 1978) and analogous behaviors and attitudes among "problem drinkers" and heavy marijuana users (Jessor, Chase, and Donovan 1980; Jessor, Donovan, and Widmer 1980). Their findings suggest that strategies effective in reducing problems related to alcohol use may also serve to diminish problems related to the use of other psychoactive drugs.

In 1978, an estimated 51 percent of the Nation's senior high school students were abstainers, infrequent drinkers, or light drinkers. About 10 percent of these students had used marijuana within the last month. The remaining 49 percent of senior high school students were moderate, moderate/heavier, or heavier users of alcohol. Approximately half of these students also had used marijuana within the last month—nearly five times as many as those who were abstainers or light users (figure 2). These findings indicate a need for widespread efforts to minimize levels of use, especially the development of heavy alcohol use and the polydrug use that attends it, and to develop intervention strategies and policies to reduce problems arising from heavier alcohol and polydrug use.

Technical Notes

The technical notes provide background information on the survey and the variables on which the statistics in this report are based.

Background Information on the Research Triangle Institute Surveys

Two national probability surveys of adolescent drinking practices were conducted by the Research Triangle Institute (RTI), one in 1974 under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and one in 1978 under joint contract to NIAAA and the National Institute on Drug Abuse (NIDA).

Similar sampling methodologies and questionnaires were used in the 1974

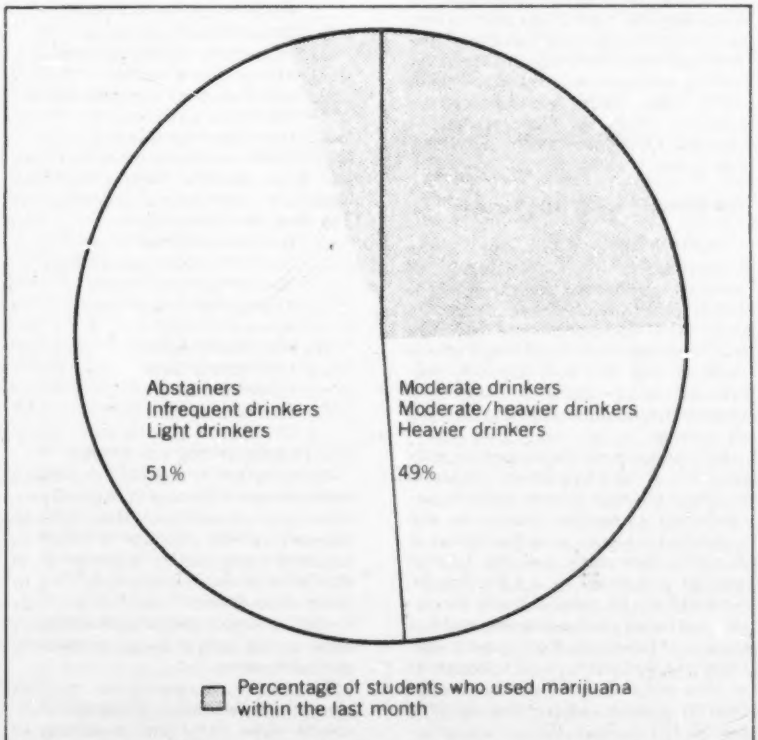

Figure 2. Marijuana use within the last month by two categories of student alcohol users —light or nonusers and heavier users.

and 1978 surveys in order that findings on adolescent drinking practices could be compared, providing information on trends in drinking practices during the 4-year interval. However, only senior high school students (10th to 12th grades) were sampled in 1978; junior high school students (7th to 9th grades) were also sampled in 1974. A further distinction in the two surveys is that more questions about the use of psychoactive drugs other than alcohol were asked in 1978 than were asked in 1974.

In both years, questionnaires were self-administered by students grouped in homerooms or classes. Instructed and supervised by RTI-trained staff, students were assured their responses would be anonymous and confidential. Using these procedures, *13,112* usable questionnaires were obtained from junior and senior high school students in 1974, and *4,918* from senior high school students in 1978.

In the spring of 1978, sampling was done by county in the 48 contiguous States of the United States and is highly representative of the 11,180,409 senior high school students at that time attending more than 20,000 public and parochial senior high schools.

For more detailed information on the methods used, types of questions asked, sampling strategy, and validity of the 1974 and 1978 survey data, readers may refer to articles by Rachal and associates (1975, 1980*a*, 1980*b*) and the technical notes in "Facts for Planning No. 1" (*Alcohol Health and Research World*, Vol. 6, No. 1, 1981).

The Drinking Levels (DL) Variable

The 1978 survey data reveal a strong association between the degree of beverage alcohol use and the extent to which other psychoactive drugs are used. The correspondence indicates that information on senior high school students' use of a licit, culturally prescribed drug—alcohol—can help identify those students likely to be using illicit drugs.

RTI researchers developed a classification of "drinking levels" (DL) used to assign the high school students surveyed to categories based on the reported frequency of consumption of alcoholic beverages and the average amount consumed on each occasion. Although the DL variable masks the distinction between the quantity and frequency of beverage alcohol use, it does represent variations in the degree of alcohol use and thereby facilitates the search for factors influencing drinking behavior.

Because analyses of the survey data reveal a strong association between students' drinking levels and their use of other psychoactive drugs, the 1978 data on polydrug use are presented in this report in tables and graphs broken down by drinking levels.

The drinking levels classification is based on responses to an array of six questions. Two questions are asked about each of the three types of alcoholic beverage ordinarily consumed by Americans—beer, wine, and liquor (whiskey, vodka, gin, mixed drinks, etc.). The six questions from which the DL variable is derived are part of a set of questions about the respondent's "current" drinking practices. This set of questions is preceded by the statement, "Now we would like to ask you a few questions about your current drinking habits."

One of the DL questions requests information about the usual frequency of consumption for each alcoholic beverage type; the other asks about the average amount consumed for each type of alcoholic beverage. For example, the following two questions about beer drinking practices are asked about wine and liquor drinking as well:

Q. 24. Let's take beer first. How often do you usually have beer?

- ___ Do not drink beer at all
- ___ Every day
- ___ Three of four days a week
- ___ One or two days a week
- ___ Three of four days a month
- ___ About once a month
- ___ Less than once a month, but at least once a year
- ___ Less than once a year

Q. 25. Think of all the times you have had beer recently. When you drink beer, how much do you usually have at one time, *on the average?*

- ___ Do not drink beer at all
- ___ Twelve or more cans of beer (two six-packs or more)
- ___ About nine cans of beer
- ___ Six cans of beer
- ___ Five cans of beer
- ___ Four cans of beer
- ___ Three cans of beer
- ___ Two cans of beer
- ___ One can of beer
- ___ Less than one can of beer

The question in the wine and liquor series about the amount consumed provides response categories assumed to be comparable in absolute alcohol to response categories in question 25 in the beer series. For example, "12 or more wine glasses" and "12 or more drinks" of liquor are considered equivalent to "12 cans of beer" in absolute alcohol content.

Responses to questions on the amount of alcoholic beverage consumed were converted to ounces of absolute alcohol. Three categories of amount were used to develop the drinking levels variable:

Small/light amounts: One or less can of beer, drink of liquor, or glass of wine on each drinking occasion (0.68 oz absolute alcohol/ethanol)

Medium/moderate amounts: Two to four cans of beer, drinks of liquor, or glasses of wine on each drinking occasion (0.68-2.70 oz absolute alcohol/ethanol)

Large/heavy amounts: Five to twelve cans of beer, drinks of liquor, and/or glasses of wine on each occasion (2.70 oz absolute alcohol/ethanol)

Information on the average amount of absolute alcohol consumed on each occasion and the frequency of consumption initially was used by the researchers to construct a 10-level classification of drinking level (Rachal et al. 1980*a*, p. 42). The 10 levels were further collapsed to create a more manageable and useful set of drinking types among senior high school students. A six-level classification of drinking practices is employed in most analyses (Rachal et al. 1975; Rachal et al. 1980*a*). Definitions presented earlier in this report are based on information in RTI's final report to NIAAA and NIDA (Rachal et al. 1980*a*, pp. 43, 48).

Further information on the history of the drinking levels variable and its construction and validity, and on the demographic characteristics of students in each drinking level as well as comparisons with similar findings can be found in a number of RTI studies for NIAAA (Rachal et al. 1975; Rachal et al. 1980*a*, 1980*b*).

Questions on Eight Types of Psychoactive Drugs

In addition to questions on alcohol use, the RTI questionnaire asked a series of questions about use of eight other types of psychoactive drugs. The statistics presented in this report are based on responses to a question about recency of use asked about each type of psychoactive drug use. The following question about recency of marijuana or hashish use was also asked about the other seven types of drugs:

Q. 61. When was the *most recent time* you used marijuana or hashish?

- ___ Within the last week
- ___ Within the last month
- ___ Within the last 2 months
- ___ Within the last 6 months
- ___ More than 6 months but less than a year ago
- ___ More than a year ago
- ___ I have never used marijuana or hashish

Following are descriptions of the eight types of psychoactive drugs about which questions on use were asked in the 1978 questionnaire:

Table 2. Prevalence of polydrug use within the last year by drinking level (Percentage distribution)*

Number of psychoactive drugs used within last year	Drinking level						
	Alcohol Abstainers	Infrequent drinkers	Light drinkers	Moderate drinkers	Moderate/ heavier drinkers	Heavier drinkers	All students
None	89.7	78.5	60.1	43.0	31.4	22.5	55.5
1 drug	8.5	19.2	31.3	37.6	38.4	35.8	27.6
2 drugs	0.7	1.0	4.2	9.4	10.4	10.8	6.0
3 drugs	0.5	0.5	2.1	3.9	5.2	9.1	3.5
4 drugs	0.1	0.6	1.0	2.0	4.9	10.5	3.0
5 drugs	0.2	0.2	0.6	2.2	4.4	4.1	1.9
6 drugs	0.1	0.0	0.3	1.0	2.9	4.1	1.4
7 drugs	0.2	0.0	0.4	0.8	1.9	2.3	0.9
8 drugs	0.0	0.0	0.0	0.1	0.5	0.8	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Percentages should be interpreted as follows: Only 22.5 percent of heavier drinkers used no psychoactive drugs other than alcohol during the past year; 89.7 percent of alcohol abstainers used no psychoative drugs during the same period.

- **Marijuana or hashish** (grass, hash, weed, hemp, joints, pot, or reefers)
- **Inhalants**—substances that people sniff or inhale (glue, aerosol, gasoline, lighter fluid, nail polish remover, paint thinner, poppers, snappers, or paint)
- **Heroin** (smack, horse, junk, or H)
- **Cocaine** (coke, crystals, or snow)
- **Hallucinogens** (LSD, mescaline, peyote, acid, angel dust, hog, magic mushrooms, or peace pills)
- **Stimulants** (uppers, bennies, bombitas, dexies, diet pills, greenies, pep pills, speed, splash, or whites)
- **Tranquilizers** (downers, Valium, Librium, Equanil, or Serax)
- **Barbiturates** (sedatives, downers, barbs, blues, cibas, goofballs, quads, rainbows, red devils, soapers, or yellow jackets)

Presented in table 1 are statistics on the prevalence of use in the month preceding the survey for each of these eight types of psychoactive drugs distributed by drinking level. The distributions show a high correspondence between increases in prevalence of psychoactive drug use and the level of alcohol use. For each psychoactive drug considered, there is a consistent increase in prevalence with each drinking level.

Polydrug Use

Polydrug use refers both to multiple psychoactive drug use—use of more than one psychoactive drug at different points in time—and simultaneous use—use of two or more psychoactive drugs at the same time. In this article, only multiple drug use is considered. Findings on the simultaneous use of alcohol and marijuana are the subject of "Facts for Planning No. 5."

The questions on recency of use of eight types of psychoactive drugs (discussed above) do not distinguish between multiple and simultaneous drug use. Responses can nonetheless be used to estimate the extent of multiple drug use as a general measure of number of drugs used rather than a specific measure of the number of drugs used individually.

The operational definition of polydrug use adopted here is the use of two or more psychoactive drugs other than alcohol over a specified period of time. Statistics on polydrug use presented in this report are based on a count of the number of psychoactive drugs that students report using during a specified time interval. For example, a student who responded that he or she had used marijuana or hashish within the last week, inhalants within the last month, heroin never, cocaine and hallucinogens more than 6 months ago but less than a year ago, stimulants more than a year ago, tranquilizers within the last 2 months, and barbiturates within the last month would be assigned the following values on several interval-specific scales of polydrug use:

- **Lifetime prevalence of polydrug use:** A total of seven types of psychoactive drugs were ever used (all types except heroin).
- **Polydrug use within the last month:** A total of three types of psychoactive drugs were used within the last month (marijuana or hashish, inhalants, and barbiturates).
- **Polydrug use within the last year:** A total of six types of psychoactive drugs were used within the last year (all types considered except heroin and stimulants).

In table 2, the prevalence of polydrug use among students in each of the drinking levels is distributed by the extent of multiple drug use within the last year, that is the number of different drugs used. Statistics are also provided on the percentage of nonusers within each drinking level.

Note that the distributions in table 2 show the same remarkable correspondence between the prevalence of polydrug use and drinking levels as exists for the prevalence of each of the eight types of drugs independently distributed (table 1 above).

Types of Statistics Reported

Prevalence rates. Expressed as percentages, prevalence rates represent the extent of marijuana and polydrug use among students within six different drinking levels. Technical definitions of prevalence and discussion of sources of variation in prevalence rates related to the measure used can be found in "Facts for Planning No. 1" (*Alcohol Health and Research World*, Vol. 6, No. 1, 1981).

Weighted data. The reported numbers or percentages are based on "weighted" observations, that is, the sample expanded to a national basis. "Weights" assigned individual cases are adjusted so that the sample represents the geographic and demographic structure of the general population of high school students from which it was drawn. Students who fail to provide answers to specific questions are excluded from the sample for that question. The number of missing cases never exceeds 2 percent of all cases for any given question.

In general, percentages based on the weighted and unweighted RTI national probability samples (1974 and 1978) are comparable (Rachal et al. 1980*b*). This indicates that the RTI samples are highly

representative of the national population of high school students.

Mean percentages. Percentages cited in the text, tables and figures are mean or average percentages. Mean percentages represent the midpoint of a percentage range within which there is a 95 percent chance that the true national average will fall. The use of national prevalence data in local planning should be based on an estimated percentage range rather than on an estimated mean percentage. Further discussion of this point can be found in the technical notes in *Facts for Planning No. 1*. Guidelines for estimating the standard error and for calculating the percentage range for statistics based on the 1978 sample of 4,918 respondents are provided by Rachal and associates (1980a).

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*These publications are available for purchase from the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161.

FACTS FOR PLANNING NO. 3

U.S. Teenage Alcohol Use In Unsupervised Social Settings

Cherry Lowman, Ph.D., NCALI Staff

Survey research shows that alcohol use is widespread and routine among U.S. teenagers several years before they reach the age at which public purchase and consumption of alcoholic beverages become legal. Viewed by teens as a symbol of maturity, drinking plays a ubiquitous role in adolescent social development (Harford, in press; Jessor and Jessor 1977). By the time students reach the 12th grade, alcohol abstainers are in the minority (*Facts for Planning No. 1*).

When, where, and with whom teenagers drink—the social contexts of teenage alcohol use—is a subject of interest to researchers, program planners, and policymakers. Recent research on teenage drinking contexts reveals that the earliest exposure of most youth to alcohol occurs on special occasions at home, under parental supervision (Harford in press; Harford and Spiegler, in press *a*, in press *b*). The research also indicates that teenage drinking in social contexts where adults are present is moderate. Heavier and more frequent drinking occurs among teenagers who use alcohol in unsupervised settings with peers (Harford in press; Rachal et al. 1975).

Drinking in unsupervised peer settings increases with age and parallels increasing independence and disengagement from parents. Drinking in unsupervised contexts can lead to negative social, health, or legal problems—such as driving while intoxicated and traffic accidents. Consequently, information on the prevalence of drinking in different types of unsupervised peer settings can be valuable to planners in designing, evaluating, or prioritizing strategies to prevent or reduce problems arising from teenage alcohol use.

Data on the social contexts of drinking were collected as part of a national probability survey of drinking practices among U.S. students in grades 10 to 12, conducted in the spring of 1978 for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) by the Research Triangle In-

Note: Facts for Planning No. 1, Prevalence of Alcohol Use Among U.S. Senior High School Students, was published in Alcohol Health and Research World, *Vol. 6, No. 1, 1981. Facts for Planning No. 2, Alcohol Use as an Indicator of Psychoactive Drug Use Among the Nation's Senior High School Students, is on pages 41-46 of this issue.*

stitute (RTI). The 1978 survey replicates an RTI national survey of youthful drinking practices conducted for NIAAA in 1974 among students in grades 7 to 9 as well as those in grades 10 to 12. The survey instruments were questionnaires filled out by students in homerooms or classes, under the supervision of RTI staff. (See technical notes at the end of *Facts For Planning No. 2*, page 43, for background information on the two surveys.)

In both 1974 and 1978, students were asked the same question about the frequency of alcohol use in eight contexts—three contexts under adult supervision (dinner at home, special occasions at home, and teenage parties) and five contexts unsupervised by adults (teenage parties, teenage hangouts, in cars at night, at school-related activities, and alone). The drinking context questions and choices of responses are reproduced in the box below.

Findings are reported on the number of students who "often" use alcohol in a specific context, a measure based on the total number or percentage of students who selected the responses "frequently" or "most of the time." Estimated percentages and numbers are derived from weighted observations in order to approximate the nationwide extent of alcohol use in different social contexts. (See technical notes for information on previous analyses of data on social contexts, and for details on the use of weighted data.)

The summary of highlights focuses on the most current findings, those from the 1978 survey of senior high school students. Results from the 1974 survey that show similarities in patterns of alcohol use between junior high school and senior high school students also are discussed.

Social Contexts Question
From 1974 and 1978 RTI Surveys

Findings on drinking patterns in different social contexts are based on the responses of senior high school students to the following questions that appeared on both the 1974 and 1978 Research Triangle Institute questionnaires.

Please indicate how often you drink beer, wine, or liquor in each of the following settings, places, or occasions. *Mark X on one blank line in each row.*

Never drink or don't drink in this setting	Sometimes	Frequently*	Most of the time*	
___	___	___	___	At teenage parties when others are drinking and your parents or other adults *are not* present
___	___	___	___	At home on special occasions such as birthdays, or holidays such as Thanksgiving, etc.
___	___	___	___	Driving around or sitting in a car at night
___	___	___	___	At dinner at home with the family
___	___	___	___	At places where teenagers hang around when their parents or other adults *are not* present
___	___	___	___	At a teenage party when others are drinking and when your parents or other adults *are* present
___	___	___	___	During or after a school activity such as a dance or football game when your parents or other adults you know *are not* present or can't see you
___	___	___	___	Alone—when no one else is around

*For purposes of this report, percentages of students who "often" drink in a particular setting combines the percentages of students who responded "frequently", or "most of the time."

Highlights of Findings

- **Nearly six times as many senior high school students often drink alcoholic beverages on special occasions at home as do those who often drink alcoholic beverages at dinner at home.** In 1978, an estimated 3.7 million or 34 percent of senior high school students often drank at home on special occasions as compared with 700,000 or 6 percent of senior high school students who often drank alcoholic beverages at dinner at home with the family. The levels of routine and festive alcohol use at home were relatively constant over the three grades of senior high school (table 1).
- **More senior high school students often drink when at teenage parties unsupervised by adults than at teenage parties where adults are present.** In 1978, an estimated 5 million or 45 percent of senior high school students often drank at teenage parties unsupervised by adults as compared with the 2 million or 19 percent who often drank at teenage parties where adults were present.

Table 1. Percentage of senior high school students who often drink alcoholic beverages reported by grade and sex for eight settings or occasions, 1978*

Drinking setting or occasion	10th grade		11th grade		12th grade		All grades	
	% Boys	% Girls	% Boys	% Girls	% Boys	% Girls	% Boys	% Girls
Teenage parties, peers only	40.6	39.3	48.3	43.5	52.6	44.8	47.1	42.4
Teenage parties, adults present	15.8	19.4	20.7	18.6	18.1	16.4	23.6	19.4
Hangouts, peers only	30.0	26.4	34.9	26.0	35.8	27.7	33.5	26.7
School activity, peers only	24.1	22.3	31.7	23.4	30.2	23.5	28.6	23.0
In cars at night, peers only	20.0	19.0	26.9	19.2	28.0	18.3	24.9	18.8
At home, dinner with family	5.9	7.2	5.2	5.4	5.3	8.7	5.5	7.1
At home, special occasions	33.8	35.2	33.1	32.6	30.0	37.4	32.3	35.1
Alone	9.4	5.9	6.9	4.6	8.3	2.1	8.2	4.2

*Interpret percentages as follows: "In 1978, an estimated 41 percent of 10th grade boys often drank alcoholic beverages when at teenage parties where no adults were present."

- **More senior high school boys than girls often drink at unsupervised teenage parties.** In 1978, nearly 5 percent more senior high school boys often drank at unsupervised parties than did girls. The difference was most marked among seniors. An estimated 53 percent of 12th grade boys often drank at unsupervised teenage parties as compared with 45 percent of 12th grade girls. Differences between the number of boys and girls who drank at supervised teenage parties was less marked. Only 2 percent more 11th and 12th grade boys than girls often drank at teenage parties supervised by adults. Only in the 10th grade did more girls than boys drink at supervised parties, 19 percent as compared with 16 percent (table 1).
- **One in four senior high school students often drinks during or after a school activity when adults they know are not present or can not see them.** In 1978, an estimated 2.8 million or 26 percent of senior high school students often drank alcoholic beverages during or after school functions they attended, such as dances or football games. Notably more boys than girls often drank on these occasions in the 11th and 12th grades—32 to 30 percent of boys in the two grades as compared with 23 to 24 percent of girls (table 1).
- **Nearly one-third of senior high school students often drink when they are in unsupervised settings where teenagers "hang around."** In 1978, an estimated 3.3 million or 30 percent of senior high school students often drank when they were in teenage hangouts where no adults were present. The number of senior high school boys who often drank in these types of settings increased from 30 percent in the 10th grade to 35 percent in the 11th grade. Twenty-eight percent of 12th grade girls often drank in these settings—only 2 percent more than 10th or 11th grade girls did.
- **Drinking in unsupervised contexts among junior high school students follows a pattern similar to that among senior high school students, but on a smaller scale.** Among both groups, the number of students who often drink at unsupervised parties is more than double the number who often drink at teenage parties where adults are present. In 1974, 24 percent of junior high school students often drank at unsupervised teenage parties as compared with 13 percent who often drank at supervised parties. Similarly, 46 percent of senior high school students in 1974 often drank at unsupervised parties, but only 20 percent often drank at supervised ones. (See figure 1 for other similarities in drinking patterns between junior and senior high school students.)
- **Nearly a quarter of senior high school students often drink while sitting or driving around in cars at night** (table 1). In 1978, an estimated 2.4 million or 22 percent of senior high school students reported they often drank in cars at night. More senior high school boys reported this activity than did girls—25 percent of 10th to 12 grade boys as compared with 19 percent of girls in these grades. High school students in

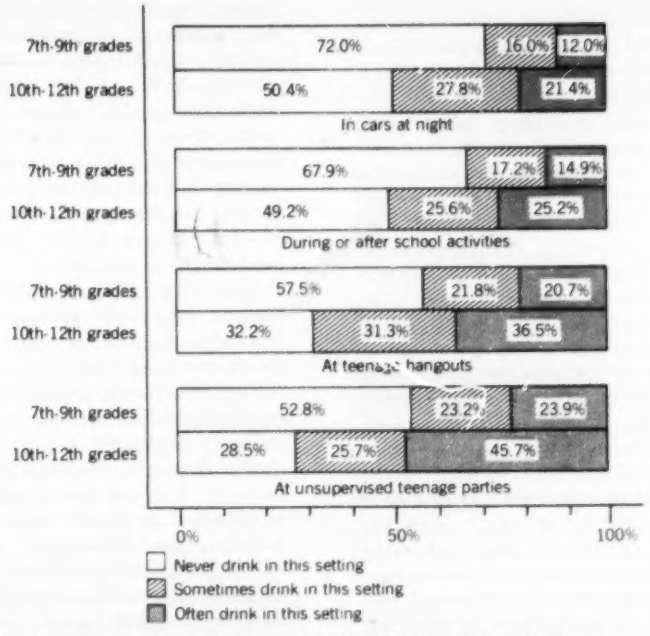

Figure 1. Frequency with which junior and senior high school students drink alcoholic beverages in unsupervised settings, 1974*

*Interpret percentages as follows: "In 1974, an estimated 24 percent of junior high school students often drank at unsupervised teenage parties as compared with 46 percent of senior high school students who did."

Table 2. Geographic variations in the percentage of senior high school students who often drank alcoholic beverages when in four unsupervised settings, 1978*

	Social context			
	Teenage parties	Teenage hangouts	School activity	In cars at night
Region				
Northeast	49.4	32.6	27.0	23.2
North Central	50.0	33.2	29.6	27.3
South	37.8	28.5	24.5	20.5
West	42.4	25.5	21.6	15.5
Community Size				
Big city	37.4	22.5	18.5	12.0
Urban fringe	51.3	33.0	26.8	20.5
Medium city	47.7	31.5	28.7	23.5
Small town	42.9	31.0	27.4	26.2

*Interpret percentages as follows: "In 1978, an estimated 49 percent of senior high school students in the Northeast often drank alcoholic beverages when at unsupervised teenage parties."

most States begin to drive at 16 years of age, usually in the 11th grade. Among boys, the number who drank in cars at night increased at the time many began to drive, in the 11th grade. About 20 percent of 10th grade boys drank in cars at night as compared with 27 to 28 percent of 11th and 12th grade boys. The number of girls who reported they often drank in cars at night remained stable, at 18 to 19 percent, in each of the tree grades of senior high school.

- **About twice as many senior high school students who attended schools in small towns often drink when sitting or driving around in cars at night as do those who attend schools in larger communities.** Approximately 26 percent of small town students often drank when sitting or driving around in cars at night as compared with 12 percent of big city students whose access to cars as settings in which adults are not present may be more limited.
- **More students in suburban areas or medium cities often drink when at unsupervised parties than do students who go to school in big cities or small towns.** In 1978, an estimated 51 percent of senior high school students who attended suburban schools ("urban fringe" in table 2) often drank when at unsupervised parties as compared with 37 percent of students who attended big city schools.
- **Fewer senior high school students in big cities often drink in unsupervised settings than those in smaller communities** (table 2; see technical notes for definitions of community size).

For example, only 37 percent of senior high school students in big cities often drank at unsupervised teenage parties as compared with 51 percent of suburban senior high school students who did.

- **More senior high school students who reside in the Northeast and North Central regions of the Nation often drink in unsupervised settings than do those who reside in the South or West.** Consistently more senior high school students who reside in the North Central region often drank alcoholic beverages in all types of unsupervised settings than did students elsewhere in the Nation (table 2). About 50 percent of senior high school students who reside in the Northeast and North Central regions often drank at unsupervised teenage parties as compared with 42 percent in the West and 39 percent in the South. Regional differences in the use of alcohol by youth in various contexts mirror general differences in the prevalence of alcohol use (*Facts for Planning #2*).
- **Less than 10 percent of senior high school students often drink when alone although their numbers decline from the 10th to 12th grades.** In 1978, nearly 700,000 or 6 percent of senior high school students often drank when alone. Twice as many senior high school boys as girls often drank when alone—8 percent of boys as compared with 4 percent of girls. The percentage of students who often drank when alone decreased from 8 percent in the 10th grade to 5 percent by the 12th grade.

Implications

The extent of unsupervised teenage drinking disclosed by the RTI surveys indicate a need for efforts to prevent or reduce problems arising from the heavier drinking known to occur under these circumstances. Findings on variations in the frequency of teenage drinking in five unsupervised contexts imply the need for a range of prevention and intervention strategies.

In *Facts for Planning #1*, it was shown that geographic variations in the prevalence of teenage drinking can be attributed in part to the racial or ethnic composition of the student population. The TRI findings on drinking contexts suggest that geographic variations also reflect conditions that influence access to unsupervised settings. For example, the relatively low levels of unsupervised drinking reported by senior high school students who attend school in big cities as compared with those who attend schools in smaller communities (table 2) may reflect more limited access in big cities to relatively isolated areas for use as hangouts or to cars in which to drink at night. Further, more teenagers in big cities can select among a wider range of alternative activities to social drinking than can teenagers in smaller communities.

A variety of stragegies—indirect and direct—are needed to reduce or minimize teenage drinking and associated negative consequences. Indirect strategies modify conditions believed or observed to be antecedent to alcohol problems. For example, indirect stragegies to reduce unsupervised teenage drinking could focus on environmental modification of popular settings; provision of social alternatives to unsupervised drinking; or educational programs to help students develop decisionmaking and other social skills useful in dealing with high risk situations. Indirect strategies can reduce the extent of unsupervised teenage drinking by enriching and diversifying the personal skills of youth, their social environments, and their social alternatives. Many indirect strategies thus can serve broad mental health goals as well as objectives specific to alcohol problem prevention.

There are two especially dangerous types of unsupervised teenage drinking—solitary drinking and driving while intoxicated—that justify the implementation of direct as well as indirect strategies. Examples of direct strategies include public policies that regulate access to beverage alcohol; treatment services for teenagers with existing alcohol problems; and public awareness campaigns or driving safety and health education programs that furnish information on the potential dangers of alcohol use.

The decrease between the 10th and 12th grades in number of students who often drink when alone indicates that this type of unsupervised drinking is largely experimental. However, most alcohol-dependent students in need of treatment are included in the 6 percent of all senior high school students who engage in solitary drinking. The extent of nonsocial, isolated drinking among teenagers warrants a number of direct strategies; for example, increasing the awareness of health planners; educating students about the potential dependence on alcohol and other dangers known to be associated with solitary drinking; and seeking out lone drinkers in need of treatment.

Students who often drink in unsupervised peer settings are more likely to drive while in-

toxicated or ride in cars with intoxicated drivers than are students who drink under adult supervision. Teenage drivers and passengers returning from parties, hangouts, or school activities or who drink in cars are at high risk for automobile accidents. Direct intervention is justified in places where such drinking patterns are common. Strategies to address this serious problem might include driving safety programs, organized parental chauffeuring, transportation by school bus to and from extracurricular school activities, intensification of police patrols in areas known to be frequented by driving-drinking teenagers, and revision of public policies regulating access to alcohol.

The best mix of strategies for a given community depends on characteristics of the local environment, the nature and extent of problems related to teenage drinking, the degree of public awareness of these problems, and the social and economic resources available to solve them. For example, to improve lighting on schools grounds and hangouts is a more cost-effective prevention strategy in big cities than in most suburbs or small towns where many isolated settings for unsupervised drinking exist. The development of driving safety programs and a range of alternative social activities, on the other hand, represent an appropriate mix of strategies for suburban areas and small towns.

Although context-specific strategies may be effective in preventing or reducing teenage problems related to alcohol use, the widespread occurrence of unsupervised drinking in a variety of social contexts argues for broadbased community programs and policies, as well. Community-wide consensus, cooperation, and planning—involving interagency efforts and involvement by parents and teenagers—may be required to alleviate problems related to unsupervised teenage drinking.

Technical Notes

The technical notes provide background information on the RTI survey and the variables on which the statistics in this report are based.

Background Information on the Research Triangle Institute Surveys

See Facts for Planning No. 2, this issue, page 43.

Types of Statistics Reported

See Facts for Planning No. 2, this issue, page 45.

Recent analyses of the 1974 and 1978 RTI data on the use of alcohol by teenagers in various social contexts have been carried out by Thomas C. Harford and his associates in NIAAA's Laboratory of Epidemiology and Population Studies (Harford, in press; Harford and Spiegler, in press *a*, in press *b*). The percentages of students who drink in various contexts reported in their articles differ from those reported in this article. The differences derive from variations in analytic decisions.

One source of methodological variation is that sample percentages, rather than weighted percentages, were analyzed in the studies conducted by Harford and his associates. Sample percentages are better suited for hypothesis testing by linear regression. The weighted percentages reported here are useful for planning purposes since they have been adjusted to represent the Nation's high school students rather than the sample (see discussion below on the use of weighted percentages).

A second source of variation between percentages reported here and those reported by Harford and associates is that *all* respondents to the 1974 and 1978 surveys are the base for percentages discussed in this report. Previous analyses are based on student drinkers only. Alcohol abstainers, former users, and inconsistent respondents, 28 percent of all respondents, were excluded from analysis. Thus, percentages on context-specific drinking reported here are lower than ones that apply to teenage drinkers only. The percentages based on all students are useful for assessing the extent of unsupervised drinking nationwide.

A final source of methodological variation is the data base selected for analysis. The 1974 RTI data base can be manipulated to include or exclude junior high school students. Percentages of students who drink in specific contexts based on responses from students in the 7th through 12th grades are lower than those based on the responses of students in the 10th through 12th grades only (see figure 1).

Percentages presented in tables 1 and 2 are weighted and are based on answers from all respondents to the question on social contexts in the 1978 sample.

Definitions of Region and Community Size

Definition of region. The 48 contiguous States and the District of Columbia are grouped in four regions as follows. *Northeast:* Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. *North Central:* Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. *South:* Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. *West:* Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Definition of community size. These appear in *Facts for Planning #1*. They were developed by RTI staff (Rachal et al. 1980:60) who define the four types of community as follows. *Big city:* students attend a school situated within the limits of a city or urbanized area of 200,000 or more residents. *Urban fringe:* students attend a school located in the urban area of a big city but outside the city's limits. *Medium city:* students attend a school situated within the limits of a city with a population of 25,000 to 200,000 and not in the urban area of a big city. *Small place:* students attend a school located in open country, or in a place with less than 25,000 residents that is not in the urban area of a big city.

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*These publications are available for purchase from the National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161.

NEWSNOTES

Conference Explores Prevention In Work Place

Department of Health and Human Services (DHHS) Secretary Richard S. Schweiker recently said that the workplace is "the most logical setting" for preventive health care efforts that will reduce health care costs.

Speaking at an Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) conference on alcohol, drug abuse, and mental health (ADM) promotion at the worksite, Schwieker said employees should be encouraged to offer their workers incentives and guidance on how to remain healthy. The Federal Government, in turn, should offer incentives to employers to set up such preventive health care programs, he said.

"We are exploring ways such as tax incentives to encourage employers to offer worksite prevention programs. This, in turn, would stimulate health insurers and providers to offer preventive programs," Schweiker said. "We must also develop reimbursement mechanisms that emphasize cost-effective preventive health services and healthy lifestyles and habits."

Schweiker praised what he described as an encouraging trend on the part of employers to increase productivity by starting company-sponsored programs to deal with employee problems such as alcoholism on the job. "Since 1950, the number of occupational alcoholism programs in the United States has grown from 50 to more than 5,000," Schweiker said. "Programs on nutrition, accident prevention, weight control, and physical fitness are cropping up all over the country."

Schweiker's speech marked the conclusion of the 2-day meeting, which was held in Washington. Attendees heard presentations on ADM health promotion and prevention activities at the worksite, existing and future programs and strategies, and the roles of specific groups, including management, labor, and special populations.

Proceedings of the conference will be available to participants and may be published for wider distribution. For further information, contact Sidney Wolverton, Division of Prevention, ADAMHA, 5600 Fishers Lane, Room 12C-25, Rockville, Maryland 20857.

NAIC Develops Model Health Insurance Legislation

Model legislation to expand group health insurance benefits to include coverage for alcoholism and other drug dependency treatment in freestanding centers was approved recently by the National Association of Insurance Commissioners (NAIC), the 110-year-old association of State insurance regulators.

The model legislation is part of a 100-page report produced by a special NAIC task force headed by William P. Daves, Jr., chairman of the Texas State Board of Insurance. The report also contains a model benefit package. While the recommended legislation calls for benefits for alcoholism and other drug dependency equal to benefits for other diseases, the model benefit package gives more detailed guidelines.

The model benefit package calls for 30 days of inpatient care for alcoholism and other drug dependency and 30 outpatient visits, including family outpatient counseling, in each benefit period. Each benefit period, the package says, should be no longer than 1 calendar year, and a lifetime maximum of two benefit periods should be provided.

According to Daves, "The recommendations for family care and freestanding centers—if implemented—could revolutionize the way third-party reimbursement for alcoholism treatment is handled in this country. We felt that it was imperative that any comprehensive benefit package extend counseling and care to the family." Daves said the task force, which had the assistance of a blue ribbon advisory committee of insurance and treatment specialists from across the Nation, also provided guidelines to help define freestanding treatment facilities. Such facilities, the report said, should be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral; or
- Licensed, certified, or approved as an alcohol or other drug dependency treatment center by the appropriate governmental agency; or
- Accredited as such a facility by the Joint Commission on Accreditation of Hospitals (JCAH) or making progress toward accreditation.

According to Daves, "The model legislation mandates optional benefits only, leaving the decision to purchase coverage up to the group policyholder, usually an employer, through negotiations with the insurance company. We believe this is the prudent alternative because it does not stifle benefit design or drive large group health insurance purchasers toward self-insurance.

"We recognize that there is some concern in the industry about pricing this product," Daves said, "but the NAIC

believes that the time-honored technique of experience-rating guarantees that any cost containment potential in such treatment programs will ultimately be reflected in future claim experience."

Daves said that the task force will continue to work through 1982 to establish a communications network with the insurance industry, treatment providers, insurance regulators, and State legislators; expand studies into related areas; and monitor the effectiveness and implementation of recommendations. Recommendations of NAIC are used in policy making and State insurance legislation debate, but are not binding. Limited copies of the task force report summary are available by writing to Information Services, State Board of Insurance, 1110 San Jacinto, Austin, Texas 78786. Questions on the report can be directed to Rob LaRue at that address.

Meeting Focuses on Public Inebriate Issues

Participants in a recent NIAAA-sponsored meeting on public inebriate issues agreed that the primary responsibility for dealing with those issues is at the local level, but that national efforts—public and private—are needed to help local authorities and organizations find solutions.

The meeting brought together representatives of 13 organizations involved in various ways with skid row problems. NIAAA sponsored the meeting as a followup to a 3-day conference held at Racine, Wisconsin, last July under the aegis of the National Coalition for Jail Reform, the National Council on Alcoholism, and the National Association of State Alcohol and Drug Abuse Directors.

In his remarks opening the meeting, NIAAA Director John DeLuca said, "All service systems are financially fragile. In this period of change, public inebriate services—certainly among the most fragile of all—need special thought and care." He suggested that joint public/private ventures in the public inebriate field deserve more exploration, especially in urban redevelopment projects.

Several authorities made presentations. Donald Murray, director of the Criminal Justice Program, National Association of Counties Research Foundation, discussed "The Nature of the Crisis," including the ever-increasing crowding of jails and the new wave of lawsuits—based on equal protection and civil rights—filed against governmental units incarcerating public inebriates. "To permit these people to deteriorate on our streets or in our jails is a national disgrace and has detrimental implications for the alcoholism reform movement," Murray said. "The public inebriate is the most visible alcoholic and has symbolic importance for all alcoholics."

Dr. Larry Meredith, of the San Francisco Department of Health, discussed "Obstacles to Change," including the blame attached to skid row people, and the economic and political factors that give skid row programs a low priority.

Timothy Flynn, from the Center for Law in the Public Interest, Los Angeles, discussed "Opportunities for Change." He outlined legal challenges to the jailing of public inebriates and argued that the public can be shown that this is a waste of criminal justice resources.

Dr. Sheila Blume, director of the New York State Division of Alcoholism and Alcohol Abuse, discussed "The Public Inebriate and Public Policy." "The alcoholism field has been attempting to forge a constituency around alcoholism treatment needs," Blume said, "but has focused on the 'other 95 percent' because of public misconceptions about alcoholism and because of a desire to promote intervention at an early stage of alcoholism, when prognosis is favorable."

Health Professions Education Target of NIAAA Project

The Health Professions Education (HPE) Project of the National Clearinghouse for Alcohol Information (NCALI) is developing a series of programs and publications to encourage health professions educators to integrate comprehensive instruction on alcohol and drug abuse into the curricula of schools of medicine, nursing, psychology, and social work.

The project serves an important support function to the manpower and training program of the National Institute on Alcohol Abuse and Alcoholism and is designed to provide widespread dissemination of training materials to health professions education institutions.

A compilation of curriculum resources for medical education, the "Project Package for Medical Educators," includes a substance abuse knowledge survey, an annotated bibliography, medical abstracts, curriculum objectives, and other educational resource materials. It is designed to assist medical educators in developing instructional material on alcohol and drug abuse, and is available in limited quantities free of charge.

HPE staff are seeking existing health professions curriculum resource materials, including course syllabi and comprehensive lecture materials, curriculum objectives and designs, teaching methodologies, self-instruction materials, audiovisual materials, and other teaching aids. All materials will be abstracted for the NCALI computerized data base and will become part of the library reference collection.

Curriculum resource guides for educators of physicians, nurses and nurse practitioners, psychologists, and social workers are also being developed. Each guide will summarize the basic core of the scientific and technical knowledge required of an instructor in order to effectively present substance abuse material in that particular field. An annotated list of curriculum resource materials and a selected bibliography will be included. The curriculum guides are expected to be available in 1982.

Those interested in the "Project Package for Medical Educators" (order no. SP 2500) should write to NCALI, P.O. Box 2345, Rockville, Maryland 20852. Those interested in receiving order forms for the upcoming curriculum guides should write to the same address but use the following order numbers: medical educators (order no. MS 227); nurses and nurse practitioners (MS 237); psychologists (MS 239); social workers (MS 240). Those who wish to share curriculum materials with the HPE Project should send them to Coordinator, Health Professions Education Project, NCALI, P.O. Box 2345, Rockville, Maryland 20852.

Treating Alcoholism Using Altered States of Consiousness

Douglas S. Derrer, Ph.D.

Man's interest in altered mind states goes back to the dawn of time. Throughout history, mankind has used varied means to achieve changes in mood, consciousness, perception, and feeling. These have included the use of drugs, chemicals, alcohol, herbs and plants, fasting, dancing, music, chanting, sex, religious ritual, and more recently, aerobic exercise and other sports. A number of these—such as drugs, chemicals, and alcohol—have led to negative addiction, a state in which the person becomes psychologically and/or physically dependent upon particular chemicals and demonstrates the discomfort of withdrawal when unable to obtain the addictive substances.

Recently, in writings about the problem of addiction, William Glasser has pointed out that there are also positive addiction states. Notably, he singles out both meditation and the aerobic exercise of jogging as producing subjective conditions that resemble addiction. In his studies of meditators and joggers, Glasser found that, when prevented for whatever reason from engaging in their routine practice, these persons became agitated, uncomfortable, depressed and guilty, nervous, and tense. In short, they exhibited many of the signs associated with withdrawal from chemical addiction. It seems that whether the pursuit of an altered mind state leads to development of a positive or a negative addiction, the goals, the effects, and the consequences of discontinued use are somewhat the same.

Past and Present Uses of Alcohol

Alcohol has assumed a prominent role in mankind's pursuit of altered states of consciousness. Part of the reason is economic; alcohol is easy and cheap to produce. It can be made from many types of readily accessible grains, plants, and berries. Evidence of its production and consumption goes back to earliest times, and throughout history alcohol has assumed a prominent role in magic, mystery, medicine, and mysticism.

Today, alcohol is widely available, and it is estimated that some one hundred million Americans, or about half the population of the United States, are regular consumers. Despite the rational scientific attitudes of most Westerners, alcohol is still seen by many as having almost mystical and medicinal powers. It is used as a relaxant, a stimulant, an aphrodisiac, and an enhancer of appetite and an accompaniment to a meal. Many of these modern uses of alcohol go back to early historical times. It is common knowledge that alcohol was produced and consumed freely at religious and festive rituals of early peoples. The Greeks and Romans dedicated gods to wine, the grape, and fertility, which they saw as intricately interrelated. No meal, dance, bacchanal, or orgy could be complete without the consumption of alcohol. The word "libation" comes from the same root word as the word "liberation." Thus, couched in the origins of our language, is the implication that to drink is to be able to release oneself, to liberate oneself from normal conscious constraints.

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Alcohol and the Altered State of Consciousness

Much of the mystery of alcohol's effect in altering mind states lies in its apparent paradoxical ability to both sedate and stimulate. The intoxication

process begins with a perceived release of tensions and relaxation, producing in its wake a kind of stimulation usually resulting in greater social conviviality. As consumption continues, however, judgment worsens; muscle control deteriorates, causing slurred speech and unsteady gait; and sensory capabilities are lost resulting in blurred, sometimes double sight. Eventually the individual becomes dulled, confused, and stuporous, usually falling into a drugged sleep.

Although there are more than two stages of intoxication, it is interesting to note that common expressions used to describe intoxication fall into only two categories—one positive, the other negative. The first category contains words characteristic of mild euphoria and pleasant feelings: "buzzy," "high," "mellow," "feeling good." The second category includes words that refer to a state that is just short of comatose: "bombed," "clobbered," "smashed," and "wasted." Finally, from the linguistic standpoint, it should be noted that "intoxication" has as its root the word "toxin," which means poison. Therefore, to become intoxicated is literally to become poisoned.

The Alcoholic Drinker

With all of this historical and cultural involvement with alcohol, one would think that man's relation to drink and its effects upon him would be better understood. Even with a good deal of scientific research on the medical effects of alcohol on brain, mind, and body, we are unable as yet to answer some very basic questions, or even reach clear agreement regarding how to define and diagnose alcoholism.

In medicine, alcoholism is regarded as both a physical and a psychiatric disorder. But the definitions are less than clear. In addition to lack of clarity and logic in many definitions, there are other more serious problems, in that they provide few implications for treatment because they clarify little about the etiology of the disorder. Based largely on quantity and frequency of consumption, these diagnostic definitions tell us little about the person or his problems.

Despite the fact that over half the population of the United States consumes alcohol, the alcoholic is regarded as someone apart, as different from the normal stream of human beings. If, however, we accept the idea that a central reason for the use of alcohol, today and throughout history, has been to alter mood states or to change the nature of consciousness, then the alcoholic is engaged in the same primary behavior as any other person who drinks. However, the alcoholic's consumption has gotten out of control and has gone beyond socially acceptable limits.

Symbolically, alcohol and the altered mind or mood state that is produced from alcohol consumption takes on many meanings for the alcoholic. Alcohol plays such a major role in the life of the alcoholic that normal human relationships dim in importance. Alcohol becomes the constant companion, the ready friend, the comforter, the liberator, the powerful ally, the bringer of peace, and the curer of suffering, anguish, pain, and tension. Ultimately, alcohol brings deliverance through oblivion, sleep, and amnesia. Alcohol is constant and consistent; it seems to give much but makes no apparent demands. While it is true that the severity of a hangover can reduce the pleasure obtained from alcohol consumption, "surviving" such hangovers often becomes a hallmark for the alcoholic, an expression of bravado. This pursuit of the peace and tranquility that alcohol brings, which eventually leads to oblivion, is what retired Navy Captain Joseph Pursch has called sedativism.

Treatment Concerns

Most alcoholism treatment philosophies are based on the concept of total abstinence from alcohol. In addition, alcoholics are discouraged from consuming any other kind of mood- or mind-altering chemicals such as tranquilizers, antidepressants, and other legal and illegal drugs. Although they may be used on a short-term basis as an adjunct in the treatment of carefully selected patients, past studies have shown indiscriminate use of these drugs has, in some cases, merely substituted one addiction for another.

Yet, the alcoholic is faced with a dilemma. The alcoholic, like many other persons, often continues to desire to alter his or her mood states and to change his or her consciousness. But the use of chemical means is denied by the treatment program requirements. The alcoholic is not only denied alcohol, but also other opportunities for changing his mood or state of consciousness. Given the symbolic significance of alcohol for the alcoholic, total abstinence is asking him or her to give up a great deal more than just drinking. Those who fail in treatment may be reacting to a demand that they give up too much without being offered alternatives to ease the loss of alcohol.

If we help the alcoholic recognize, however, that alcohol abuse and the achieve-

ment of an altered state of consciousness are quite different matters, the ramifications are considerable. Clearly, the alcoholic *should* stop drinking. In many instances, this is an action taken to save the alcoholic's life. At the same time, however, is it necessary that the alcoholic give up all routes to altered states of consciousness?

Nondestructive Altered Mind States

Returning to our earlier discussion of the numerous means for altering states of consciousness that have been used by mankind, currently and throughout history, it becomes very clear that there are many routes to the same objective. Given this, one might hypothesize that a type of substitution therapy could be used to treat alcoholism and other addictive disorders. In conjunction with the treatment philosophy that total abstinence for alcoholism is the best route to a sane and sober life, perhaps counselors and therapists also should be teaching their alcoholic patients to find ways of achieving altered states of consciousness that lead to positive addiction via nondestructive and constructive methods. For example, many treatment programs have a physical fitness component. This can be an effective means for "getting high." There is a large and growing literature on the transcendental effects of jogging—the "runner's high."

Experience with alcoholics shows that most of them have used alcohol as a way to reduce stress, tension, and anxiety and to alter disruptive emotional states. Some treatment programs provide the alcoholic patient with various methods of stress management, including progressive relaxation exercises, hypnosis, and meditation. Such stress management methods are also a means, if pursued regularly and extensively, of altering states of consciousness in a positive and constructive manner.

Incorporating both physical fitness and stress management procedures into an alcohol treatment program avails to the alcoholic ways of getting high that are legal, safe, and constructive, and that provide a multitude of other benefits. What appears to be needed is the incorporation in our treatment approaches of a philosophy that makes it legitimate to pursue altered states of consciousness. In truth, it is not the goal of altered mind states to which society objects. Rather, the objection is to the alcoholic means of achieving the goal—and the resulting self-destructive behaviors and actions that disturb work performance and personal and family relationships and ruin human lives. What seems necessary is, first, to legitimize the goal and then to help the alcoholic substitute constructive and positive methods for achieving that goal in the place of addiction to alcohol.

All chemical means of achieving altered states of consciousness eventually lead to self-destructive results. Positive methods of achieving altered mind and mood states have demonstrable physical, psychological, and spiritual benefits. A reexamination and a renewed emphasis on the value of religious rituals, fasting, aerobic exercise, meditational practices, and other positive means of achieving altered mind states in the treatment of addiction may be a valuable contribution to increasing treatment successes.

BOOK REVIEWS

Alcoholic Women in Treatment, by Eileen M. Corrigan. New York: Oxford University Press, 1980 (191 pp.; $14.95).

This volume is a significant addition to the empirical literature on alcoholic women. Corrigan's work supports and elaborates many findings reported in the existing research literature; however, she is timid about systematically relating her own findings to previously reported studies and also is reluctant to speculate on suggestive new results with a view toward shaping the future direction of the field.

Unlike previously published investigations of the onset, course, consequences, and treatment outcomes of female alcoholism, this book provides comparative information on the nonalcoholic sisters of female patients interviewed and also provides a discussion of data resulting from interviews with a small number of husbands. The results of the interviews with the patients' sisters may be seriously biased by the exclusion of those cases in which either the patient or the sister would not give permission for an interview (45 of 98 living sisters), or in which the researchers determined that either the sister could not be located or she had a drinking problem (19 of 98 sisters).

Results from interviews with 33 sisters of alcoholics indicate that the sisters are more likely than the alcoholic women to recall a happy childhood, to be currently married, and to score higher on an index of social integration; they are less likely to show psychiatric impairment. Differences between patients and sisters in rates of use of tranquilizers and sleeping pills and of drinking for escapist reasons or in response to nervousness or depression are exaggerated by the exclusion of problem-drinking sisters. No attempt is made by the author, however, to explain findings contrary to hypothesized trends. For example, sisters received worse grades in school than did the alcoholic women and were more likely to receive parental approval for non-gender-specific activities, the only measure of role confusion on which sisters were differentiated from the alcoholic patients.

These findings suggest that, perhaps, in spite of exceptional academic performance relative to their sisters, prealcoholic females experience little parental support. The subsequent discussion of gender-role-related traits that successfully predict alcoholic drinking does not specify which characteristics do distinguish between the alcoholic women and their nonalcoholic sisters. Questions about why the familial experiences of the patients and their sisters differ remain unanswered. For example, what factors contribute to the differential perceptions of parental support described by patients and their sisters? Are there age differences between sisters and patients that might account for differing responses from parents? How might families with two alcoholic daughters differ from those with only one?

As Corrigan notes, findings from interviews with the husbands of the alcoholic women also are biased; only those husbands who were living with their wives at the time of the research (47) and whose wives gave permission for the spouse to be interviewed (33) were approached for an interview. Interviews with this select group of husbands indicate that they were reluctant to define the wives' problems as alcoholism and that husbands may well support the denial process for alcoholic women. Although another 47 women had previously been married and were separated or divorced at the time of the research, the author contends that "only 7 husbands, representing 7 percent of those ever married, actually left their wives because of heavy drinking. . . cast(ing) grave doubt on the belief that husbands are more likely than wives to leave an alcoholic spouse." Given the lack of a comparison to spouses of alcoholic men and the nature of the data available, such a conclusion does not seem warranted. Of the remaining formerly married women, how many were separated or divorced following the onset of problem drinking? It would be interesting to learn if the former husbands of these women would report that the divorce or separation was not due to drinking.

The most important contribution of this research consists of the followup of women 1 year after treatment. It is interesting that the groups of women most likely to report abstinence at followup are extremely similar to those groups likely to hide their drinking before entering treatment. Professional women and women in higher socioeconomic classes are described as more likely to attempt to conceal their drinking before treatment because of strong ties to conventional roles and to significant others. During followup interviews, women who were white, professional, or members of high socioeconomic classes evidenced higher rates of abstinence than did black, nonprofessional, or lower socioeconomic status patients. The author suggests that treatment outcomes are not only related to the presence or absence of social support following treatment, but also related to the orientation of support groups toward drinking. Lower class urban women are more likely to be members of groups that define heavy drinking positively, but members of the support groups surrounding higher status women disapprove of female heavy drinkers. A potential source of bias stems from the lack of followup information primarily from lower class subjects; however, followup losses do not represent a serious problem.

Followup data clearly indicate that psychiatric impairment is substantially reduced following drinking cessation, that involvement in AA in combination with other treatment is positively related to maintaining abstinence, and that the number of prior treatment episodes strongly influences outcomes.

Although the stated research goal of this study is merely to provide descriptive information on alcoholic women, the data collected could conceivably provide a basis for inductively generating hypotheses about the course of alcoholism in women. For example, the author cautions researchers attempting to analyze the telescoping of symptoms to analytically distinguish time periods during which women are social drinkers from time periods during which they are problem drinkers.

Data on the progression of symptoms in women, patients' statements about the stigma of alcoholism in women, and husbands' reports of denial could begin to provide us with insights into how the process of telescoping relates to help-seeking behavior among alcoholic women; it may well be that informal social controls, after the onset of problem drinking, encourage the woman to seek some type of treatment earlier in the progression of the disease than is the case for men. As this study and others indicate, women and their families are likely to define drinking problems as psychiatric problems and to seek help initially from mental health professionals. Creative analyses of case histories available from this study could begin to shed some light on how these processes unfold.

The major findings resulting from the study are neatly summarized in the introduction to each chapter. This reviewer feels that the author could more fully exploit the richness of her data and more clearly delineate the relationship between her own work and findings of other researchers, to further enhance the usefulness of this very interesting contribution to the research literature.

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Evaluating Alcohol and Drug Abuse Treatment Effectiveness, edited by Linda Carter Sobell, Mark B. Sobell, and Elliott Ward. New York: Pergamon Press, Inc., 1980 (188 pp.: $20).

The editors state in their introduction to this book that the intent is for the reader to understand that alcohol and drug treatment outcome evaluations need not be mysterious and complicated affairs restricted to research projects, but that such evaluations are feasible and necessary undertakings within clinical treatment settings. The eight chapters are designed to provide an exposition and understanding of the major practical problems involved in designing, conducting, and interpreting treatment outcome evaluations; a review of the use of innovative measures and procedures; and a discussion of exemplary studies.

In accordance with these objectives, three chapters are devoted mainly to overviews of methodological issues. Maisto and Cooper review general methodological problems in both alcohol and drug treatment outcome research and offer some useful suggestions for improving reliability and validity as well as increasing the number of followup questionnaires returned. Callahan and Rawson provide a more specific review of behavioral assessments and treatment evaluation in the field of narcotics addiction, while Sobell and Sobell focus on studies concerned with the validity of self-reports, official records, laboratory tests, and other data-gathering mechanisms.

Three chapters discuss innovative programs and studies. Pomerleau and Adkins describe behavioral treatment programs for middle-income problem drinkers, which use positive reinforcement techniques rather than the aversive conditioning methods more commonly employed in behavioral studies. Rewarding a desirable behavior certainly seems an attractive and potentially effective alternative to merely continuing to punish an undesirable behavior, especially when that undesirable behavior has been repeatedly and more severely punished

to no avail in the past. Boudin reports on the evaluation of the effectiveness of a contingency contracting program for drug abusers in which followup data is obtained by paying for items such as daily logs and urine samples. The use of frequent followup telephone contacts to obtain more complete and valid outcome information is recommended by most of the contributors to this volume. Since these frequent contacts may provide a form of treatment that itself affects outcome, the Sobells and their coworkers describe a study in which one objective is to compare the effects on outcome of two forms of telephone contacts, differing in the extent of interpersonal interaction.

The chapter by Maisto and McCollam accounts for fully one-third of the book. It is a worthwhile use of space. The authors review in considerable detail 27 followup studies that employed multiple outcome criteria in order to gather information relevant to such questions as: Is the use of abstinence as the exclusive or predominant criterion of successful outcome for alcoholism treatment justified? If drinking behavior alone is not a sufficient indicator of treatment outcome, what other areas of life functioning should be included? How does change in one area of functioning relate to change in other areas? If other areas of functioning do not improve unless drinking improves, are the others really necessary? Are there some groups for which drinking behavior is a sufficient criterion and other groups for which it is not? While no dogmatic conclusions are reached and the data may be interpreted in terms of one's preconceived biases, the chapter is interesting, readable, and thought provoking.

Throughout the book we are confronted with the internal struggle of the contributing clinician scientists. As scientists, they deplore the methodological failings of the treatment evaluation literature, espouse the importance of accountability and cost-benefit analyses, and describe well-known procedures for evaluation research designs. "Adequate methodology and technique are available; all that is necessary are professionals willing to use diligence in their application of these methods," one author notes.

As clinicians, however, they are familiar with the practical problems of implementing these designs and dealing with sophisticated methodological difficulties. Caddy, for example, took on the presumably straightforward task of doing an independent followup of a group of patients previously treated and followed by the Sobells. Much of his discussion is concerned with the problems he encountered and his attempts to manage them. One almost sees him sitting back, perspiring, and wondering how he got himself into such an endeavor. He questions whether it is really possible to develop a treatment outcome evaluation model that sustains scientific rigor in the face of the major practical considerations that must be met in any clinical treatment agency, but affirms, "I am convinced that this question can be answered affirmatively!" A statement more of faith, it would seem, than of demonstrated fact. In a somewhat similar vein, the Sobells discuss ways to optimize the validity of various outcome measures, suggesting the use of multiple measures. They conclude, however, "It also seems likely that our methods of assessing treatment outcome will never be absolutely foolproof."

The book is neither an abstract statistical text nor a "how to" manual for performing treatment evaluation research. There are honest descriptions of realistic methodological difficulties with useful hints, suggestions, and guidelines for clinicians who may wish to do outcome studies. The objective of making the problems seem less mysterious is achieved; the objective of making them seem less complex is not. This is not a criticism of the book but a reflection of the state of the art. Important advances have indeed been made. Perhaps if some of the goals were stated more modestly, the advances may seem more satisfying. The book should be required reading for government regulation writers, laboratory researchers, cost-benefit analysts, and others who need to understand the very real problems involved in trying to find out what methods work, under what conditions, according to what criteria, and for which human beings.

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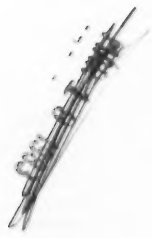

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FROM THE EDITOR

Voluntarism is the hope of the future for human services, according to many prognosticators. Inflation and funding shifts, along with shrinking resources, are causing the public and private sectors alike to look toward volunteers to fill service gaps and to play an increasingly important advocacy and support role.

For the alcohol field, the face of the volunteer is a familiar one. Voluntarism is the foundation on which the alcohol field has been built, and the notion of volunteers playing a wide range of roles is not new to those working in alcoholism prevention, treatment, and training.

In this issue of *Alcohol Health and Research World*, we explore the many facets of voluntarism in the alcohol field—looking at the rich contributions of volunteers in stimulating public awareness of alcohol-related problems and laying the groundwork for present-day treatment and prevention networks, examining specific areas in which volunteers can play a crucial role in ensuring the vitality of alcoholism services in the future, and highlighting some of the varied volunteer activities in alcohol programs throughout the Nation.

With this issue, we introduce a new format, combining a number of short articles that describe programs and projects with longer articles written by people involved in the field who offer viewpoints and provide "how-to" information. Voluntarism is so pervasive in alcoholism treatment and prevention efforts that we cannot pretend to have covered comprehensively every facet of the topic in this issue of *Alcohol Health and Research World*. We have attempted, however, to offer a sampling of the rich diversity of volunteer activities and some insights into the complex and delicate art of managing volunteers and volunteering. As always, our theme section contains a resource listing for readers seeking more indepth information. In addition, the program description articles include a contact name and address to encourage an exchange of ideas and information.

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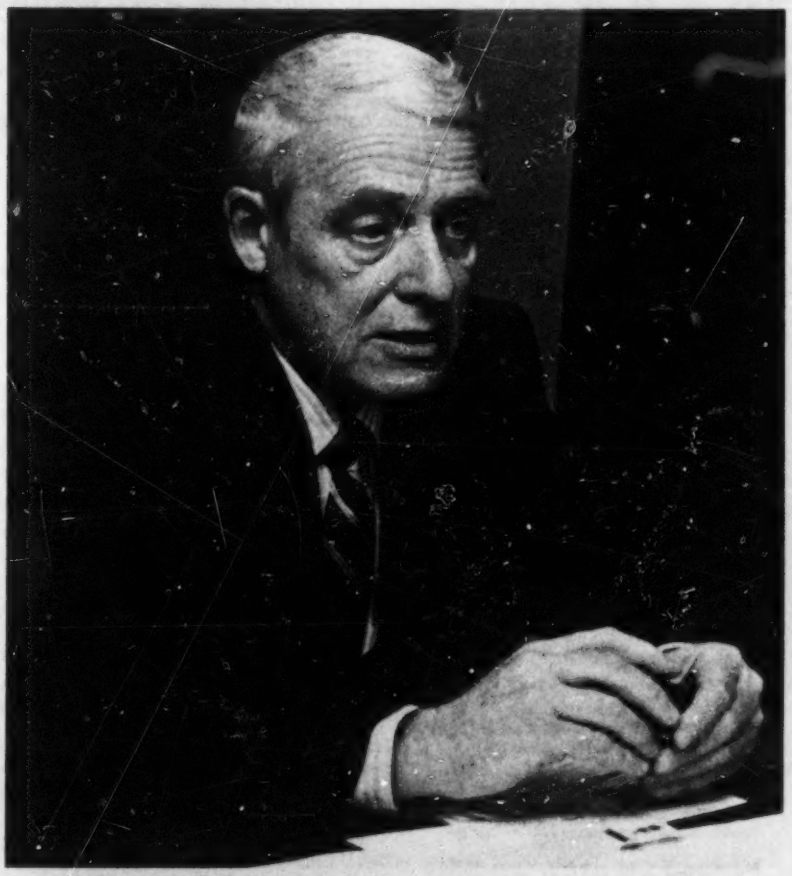


VOLUNTEERS ESSENTIAL TO THE ALCOHOL FIELD: AN INTERVIEW WITH DR. WILLIAM MAYER

Editor's Note: William Mayer, M.D., Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), discussed voluntarism in the alcohol field in a recent interview with Alcohol Health and Research World *writer John Small. This report is based on that discussion.*

There is no other health area, to my knowledge, in which volunteers have played so important a part as in the alcohol field. Volunteers have long been active in helping people who suffer from alcoholism overcome or control the disease, and have helped to raise public awareness. Although some might take exception to the term "treatment" being applied to Alcoholics Anonymous groups, I believe that this is a very real kind of treatment, and that voluntarism in this field should continue to be closely connected with Alcoholics Anonymous.

There are few diseases that so affect other people, and I think this has given rise to the participation of a great many volunteers, many of them significant others in the lives of alcoholics—people whose lives are also affected. This is reflected in the growth of Al-Anon and Alateen groups, which are totally voluntary, unsponsored activities that co-alcoholics and close associates of the alcoholic take up in their own behalf.

In directing alcoholism treatment programs, I found that a combination of both professionals and recovering alcoholics, who are often willing to volunteer, provides the best approach to helping people with the disease. Treatment programs should not be solely in the hands of volunteers, but neither should health professionals operate without the involvement of volunteers. Both can bring important insights and support to the treatment process.

Because so many people who are recovering alcoholics are exceedingly competent, constructive, and effective, many in the recovery process—as well as co-alcoholics and others concerned about alcoholism—have extended their voluntary activities beyond lending a helping hand to the alcoholic in trouble. This has given rise to such important voluntary organizations as the National Council on Alcoholism (NCA) and its State Councils on Alcoholism, which focus on education and prevention.

I feel strongly about the need to use volunteers, especially in treatment programs. Too often in the past, the volunteer has not been welcomed, sometimes because professionals don't feel they have the time to train volunteers or because they are suspicions of the volunteers' motivation. In my own experience in community programs, I have found that volunteers have a great deal to offer in helping the

alcoholic establish social interaction with others. They can provide many services that would otherwise require substantial outlays of program funds.

To make the most effective use of volunteers, it is crucial they be viewed as real employees—even though unpaid. It is also important that they be given adequate preparation and training, and that very clear contracts be made with respect to the time that they will volunteer. A business-like approach to voluntarism helps to ensure that the volunteer behaves as would any other employee in being reliable, keeping informed, and being oriented toward service. It also assumes that the volunteer has a voice in the program's activities; their special point of view is often fresh and valuable.

It is important to recognize that voluntarism operates out of enlightened self-interest. Volunteering helps the volunteer, and there is no question that people volunteer to do things partly to meet their own needs. This is not a criticism, but rather a recognition of the importance of voluntary activity in alcoholism treatment and prevention.

One example of enlightened self-interest, which has brought a new source of volunteers into the field, is the involvement of management and labor organizations in employee assistance programs across the country. These are designed specifically to help the company by preserving precious human resources and improving the productivity of the early alcoholic or the moderately impaired alcoholic who is still able to function on the job, but whose ability may be waning. And the employee assistance approach is attractive to organized labor because it is a means by which the union can serve its members. So there are great benefits for both corporations and organized labor—for hard-headed business reasons as well as for humanitarian considerations.

Likewise, I believe we will see a broadening base of voluntary support from corporations and other segments of society in raising public awareness of the problems associated with alcohol and of the resources available for intervention and treatment. A recent example of corporate voluntarism was the ABC television network's series on *Good Morning America*, which discussed the problem of teenage alcoholism.

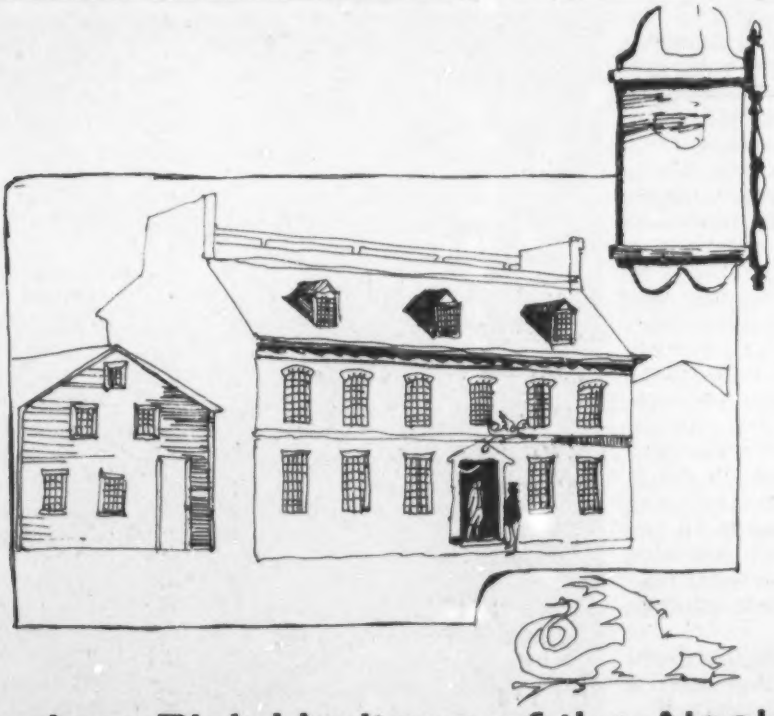
Another example is the life insurance industry's Center for Corporate Public Involvement, which goes beyond the basic objective of seeking to minimize health problems in order to maintain the insurability of insurance clients. In the spirit of public service and enlightened self-interest, the group looks for ways to bring to the public's attention the magnitude of the alcoholism problem, to reduce the stigma attached to the disease, and to make treatment and rehabilitation more widely available.

These voluntary efforts are even more important in view of reduced Federal resources for communications activities that are critical in dispelling the thousand-year history of stigma and prejudice associated with alcoholism. We shall be soliciting the cooperation and assistance of business and industry, whose interest, in my judgment, can be even more effective than government pronouncements. It's far more effective if government and industry, including the alcoholic beverage industry, can work together to inform the public and help to make this disease a matter for rational public attention.

The same objective is the focus of a new initiative within ADAMHA. The Alcohol, Drug, and Mental Health Forum on Public Understanding brings together senior communications and research staff of the three ADAMHA Institutes to work with private groups and organizations in helping to reduce stigma associated with alcoholism, drug abuse, and mental illness. The Forum will serve as a vehicle for encouraging private industry, voluntary and civic organizations, and professional groups to use their networks and resources to foster greater awareness of these disorders and support at State and local levels for treating and preventing them.

We need to communicate with the public, in a positive way, the realities of these diseases, including the information developed over the years and the new knowledge we are gaining from scientific research. In the area of alcoholism, for example, we are learning about genetic components, biochemical and physiological factors, and the relationship of alcoholism to other major diseases including cancer, heart disease, and high blood pressure. We shall have to rely on voluntary organizations to tell the public about the nature of the alcoholism and the fact that it is treatable and manageable, if not curable.

There is still a general feeling that alcoholism is somehow a defect in character or spiritual strength, and that concept—which in my judgment is absolutely wrong—works strongly against successful dealing with the disorder. Only by raising public awareness, a long-range task, can we hope to eradicate this stigma. And I expect volunteers, long active in the alcohol field, to continue to play a vital part in this process. ☐



Voluntarism: Rich Heritage of the Alcohol Field

Jill Vejnoska, Staff Writer

Public response in the United States to alcohol and the problems it may create has evolved "from a highly emotional prohibition of the substance, to a seeking of self-help among alcoholics in a society that generally rejects them, to a cultural recognition and support of the need for serious medical research into treatment methods" (Chafetz 1979). Although the three stages to which Chafetz refers are far removed from each other philosophically, they are linked historically by the presence of volunteers, always a powerful force in the alcohol field. During America's first 200 years, the country wrestled with the liquor question—who should drink, when, where, and how much. Eventually, the conflict was resolved—or appeared to be resolved—by Prohibition. When Prohibition was repealed, control of liquor consumption became a matter of personal concern—until it became clear that not everyone could drink without developing problems. In response, public and private sector organizations were formed to educate Americans about alcohol and alcohol consumption and to provide services for persons with drinking problems. Volunteers initiated, refined, and were the continuous driving force behind this evolutionary process.

While the alcohol field is founded on voluntarism to a remarkable extent, voluntary activity is not unique either to American soil or to the alcohol field. Manser and Cass (1976) write in *Voluntarism at the Crossroads*, "One must search far back in the history of western man for the origins of voluntary effort. From the very beginning of human experience, as modern sociology and anthropology have evidenced, man has striven to share with as well as to destroy his fellow man."

Religious Origins

Based on an examination of Western civilization, it appears that most volunteer movements have originated as efforts aimed at correcting societal disorder and have had some foundation in religious thought. "Religion as a source of education, social welfare, health, and other servi-

ces has been of crucial importance throughout history," explain Manser and Cass. New voluntary organizations—politically or otherwise motivated—arose only when the resources of religious volunteers were no longer sufficient to meet ever-increasing social and health needs.

One of the first documented accounts in which religious figures volunteered their services to societal disorder occurred in Ancient Rome. When the Empire collapsed, those Romans who had not been killed during an invasion by Germanic tribes were penniless and hungry, and they flocked to the Christian colonies set up by monks. Manser and Cass refer to this religious benevolence as "a new philosophy of life which, in its purest form, embodied the highest concept of assistance to others." Simply put, it was voluntarism.

During the early Middle Ages, Europe's ruling powers embraced Christianity, and consequently, voluntarism—which had previously flourished only in certain isolated communities—became commonplace on the continent. Under Charlemagne (742-814 A.D.) the monastery system in Europe was expanded and several other religious orders were formed to provide aid for the sick and weary.

In the 16th century, Calvin, Luther, and other leaders of the Reformation movement (1517-1648), advocated separating the activities of church and State, and encouraged individual initiative. Luther's works in particular conferred upon each person responsibility for his or her own salvation. Lutheran teachings ran counter to the Catholic philosophy encouraging widespread efforts to aid the needy and very nearly signalled the death of voluntarism in Europe, according to Manser and Cass.

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Focus on Social Issues

Although religious-based charitable efforts did not disappear altogether in the years following the Reformation, organized government became increasingly involved in matters of social welfare. This shift, and the changes in social structure that precipitated it, are reflected by events in England. The 18th and 19th centuries brought the Industrial Revolution to England, and economic power began to shift from the nobility into the hands of the middle class. In a change that had major implications for the volunteer movement, ordinary citizens began to demand, and then to use, increased political power. These citizens identified societal problems and formed organizations that provided aid to the needy and pressed the government to address the underlying social inequities.

Many health and social problems had gone unchecked during the Reformation period. In addition, the extensive economic, housing, and employment changes wrought by the Industrial Revolution were taking a toll on society. These citizens formed voluntary organizations to distribute food and clothes to the poor, to improve working and living conditions, to tend to the sick, and to agitate for social reform legislation. Their work was distinct from that of earlier volunteer groups in that it was directed toward achieving societal reform by political, rather than religious, means. Gradually, their goals were realized.

This massive attempt to raise the public voice to a level where it could be heard by every member of English society brought alcohol to prominence as an issue of public concern. Voluntary movements began to focus on changing the public's drinking habits because heavy gin consumption was thought to cause disorderly behavior and malnutrition, particularly among the poor. In a warning to his countrymen, author Henry Fielding wrote that gin would "fill alms houses and hospitals and. . .infect the street with stenches and diseases."

Voluntary social reform groups agitated for legislation to impose strict limits on the amount of liquor to be produced and consumed in the country. Parliament at first exhibited little interest in the gin issue. But from 1720 to 1750, volunteers virtually deluged public officials with petitions

calling for legislation against the production and sale of gin, published pamphlets excoriating the lethal effects of "cheap liquor," and wrote treatises against gin's presence in England. These well-executed moves forced the Government to take action. In 1751, Parliament passed the Gin Act, which imposed a duty on spirits and stopped distillers, shopkeepers, and grocers from retailing liquor.

Ultimately, however, the Gin Act failed to accomplish what it had been set up to do. Gin consumption was not curtailed, mainly because a thriving black market for the substance had sprung up. The majority of England's citizens were enraged at what they interpreted as an infringement of their personal rights. They expressed their dissatisfaction in the streets—rioting, attacking law enforcement officers who confiscated their caches of illegally-obtained gin, and destroying establishments that would not sell them liquor—and at the polls. The Walpole government that had created the Gin Act was defeated and the new government repealed the Act. Voluntarism had just crossed paths with one of the most sensitive of all social issues: prohibition. Throughout history, most voluntary movements dedicated to combating alcohol problems and alcoholism have had to assess the feasibility of advocating prohibition. In the United States, prohibition followed the same path that it had in England: starting as a small voluntary movement, it was made national law, but ultimately, it was rejected.

Voluntarism in America

A relationship has always existed between the "liquor question" and voluntarism in America. Who should drink, what, where, when, and how much have been important questions to Americans for the past 300 years. The unique historical experience of voluntarism in the alcohol field in America is rooted in the unique history of the country itself.

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According to James T. Peterson, associate professor of social services at Cleveland State University, "The essence of American society is the voluntary participation of its members. The more we must do things because we are ordered to or because we have no other choice the less free we are. The more choices we have about what we will do with our talents, money, and time, the more that we do as a result of our own volition rather than someone else's—the freer we are" (1981).

America's first settlers came looking for freedom: freedom of thought, expression, and association. Those who exercised their "free, individual initiative" succeeded in the New World. Those who did not, failed. This sums up—though rather simplistically—the overriding philosophy in America in her founding days. Those settlers who had toiled long and hard to secure their places in the New World were reluctant to provide for the people who had not taken advantage of America's freedoms. This lack of voluntary benevolence was reinforced by Puritanism, which stressed the "as ye sow, so shall ye reap" theory. It is not hard to understand why a vacuum of services developed in 17th and 18th century America.

Nonetheless, there were many who desperately needed services. As had happened in Europe from ancient times through the end of the Middle Ages, it fell to religious groups to provide for the needy. Manser and Cass write that "colonial churches were active in providing help, albeit only to members of their own congregation" (1976). "Failure"—the need of some citizens for voluntarily-provided services—came to be viewed as a moral problem in the New World.

Alcohol played an essential role in the daily conduct of colonial life. Employers, political officials, and even ordinary citizens, in need of their neighbors' helping hands, used liquor as an inducement to labor. Ian Tyrrell writes that a man "was considered parsimonious and unsociable" if he did not serve liquor to his neighbors at social or work-related events (1979). This same attitude prevailed at places of business, for "Americans believed that drink was a stimulus to labor and a means of reviving strength after heavy work." Voters, too, said "nay" to elections at which liquor was not

served, a philosophy that explains why taverns were the sites of most elections in colonial times and why the expense account for George Washington's 1758 Virginia House of Burgesses campaign ran to 37 pounds 7 shillings, "of which over thirty-four pounds was for brandy, rum, cyder, strong beer, and wine" (Tyrrell 1979).

While drinking was an integral part of colonial life, heavy drinking came to be blamed for more and more of America's social problems. The general population shared Mather's view that the "abuse of drink" came "from Satan." As such, it was a moral problem that would have to be solved through moral or religious means.

In the 18th century, the structure of American political and legal institutions and American concepts of democratic values combined to promote the development of voluntary organizations to effect change in many spheres of society (Tyrrell 1979). Voluntarism developed as a uniquely American response to social needs, drawing on resources from all segments of society to address the needs of the poor and the sick. However, leaders of the effort to control problem drinking continued to be religious figures rather than businessmen. Efforts to minimize alcoholism did not gain supporters among the general population, in large part because drinking was such a vital part of American life and many people saw efforts to control drinking as a threat to the nation's economic stability.

Toward the end of the 18th century, efforts to address alcohol-related problems gained broader support, as a number of factors combined to create economic, social, and political stability. The Revolutionary War, independence, and the War of 1812 led to a "gradual erosion of established authority" (Tyrrell 1979). The tavern system, an important focal point of community life, was particularly affected in this period. The rapid expansion of the turnpike system caused taverns to become even more indispensable as places of refreshment and relaxation, and as a result, their number rose dramatically in the United States. Tavern ownership until now had been strictly regulated, but as the financial benefits of tavern ownership increased, so did the number of illegally opened taverns. This contributed to the economic, political, and social turmoil in the United States at the end of the 18th century. Tyrrell observes that many citizens interpreted this as a "decay in 'publick morality,'" brought about by "the freer dispensation of it (whiskey) by lower-status tavern keepers not bound by the restraints of colonial law." Concerned by the toppling of previously stable authority figures and institutions, Americans began to agree that alcohol consumption was a serious social problem.

Movement To Change Drinking Habits

Two powerful groups led the early voluntary movement to change the country's drinking habits. The Congregationalists, a religious group that had dominated spiritual affairs in New England, and the Federalist political party, which had for years dominated American politics, were both feeling the effects of a loss in influence as American society reacted to the changing political and economic environment. These 2 groups formed the Massachusetts Society for the Suppression of Intemperance (MSSI). Like many of their countrymen, MSSI members felt that the social instability that characterized America in the early 19th century was in large part caused by alcoholism and heavy drinking. The MSSI was, however, a shortlived movement. Many Americans were convinced that society members, the Federalists, and the Congregationalists, stood to profit from the reform efforts. While the MSSI said its mission was to restore the "publick morals," its members appeared to be equally concerned with regaining their authoritative positions in America. Tyrrell says that the Federalist-Congregationalist alliance failed because "rather than attempting something new. . .sought merely to restore the old system of legal controls."

The demise of the MSSI did not reflect a declining interest in controlling the use of alcoholic beverages. According to Tyrrell, "Within 10 years, new organizations would emerge which would discard the heritage of the past and attempt to exploit the potential of the voluntary organization as a vehicle for reform. Soon temperance societies would develop a vital organization, an articulate ideology, and a committed leadership with which to attack the social problems of the Jacksonian era."

Temperance Groups Gain Support

Increasingly, heavy drinking and alcoholism came to be viewed as a significant problem by the majority of Americans—not just a small group of politically and religiously motivated persons. This reflected an overall consciousness on the part of middle class Americans of the abject poverty affecting many Americans. Religious resources were obviously insufficient to solve the

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VOLUNTARISM IN THE ALCOHOL FIELD: THE COMING DECADE

Jane Matheson, Ph.D.

Given the rapidity and unpredictability with which events in this world are moving, attempting to project the future of the volunteer movement would require an extraordinary hubris. This is especially so since voluntarism and voluntary associations are strongly influenced by and, in turn, affect political and economic events in our society. It is possible, however, to present some of the historical factors that have affected the volunteer role, and to discuss current trends that seem to be emerging.

In general, it would appear that the role of the volunteer is expanding and that the climate for voluntary activities is a positive one. Given the current social and economic trends, it would seem that this role will continue to have greater validity and attractiveness for Americans. It offers a way to make a personal statement about issues of concern in what has increasingly become a huge and remote social system.

There has been a long and distinguished history of voluntarism in the alcoholism field, frequently involving two clearly identifiable roles: the volunteer as service provider and the volunteer as advocate. The tradition of volunteer advocacy in the alcohol field can be found in public records as far back as the 19th century when members of the Washingtonian movement began to advocate for public responsibility in treatment of the alcoholic. These citizen advocates were heavily involved in the development of hospitals and other care settings for alcoholics and their families.

The alcoholism field differs from other public health areas in that volunteer involvement predates professional interest in the issue. Alcoholics Anonymous, the preeminent treatment

modality in the field, is a self-help program based solely on the voluntary activities of its members, long-recognized as the single most effective method of treating the alcoholic. Thus, the alcohol volunteer enjoyed a unique position within the health care field, serving as caregiver. For some time, this caregiving role appears to have overshadowed the advocacy role of the volunteer in the alcoholism field.

Volunteers: Dual Role

With the development of the National Council on Alcoholism in the 1940s and 1950s the role of the volunteer as an advocate for services to alcoholics and their families expanded. At the same time, volunteers were also providing very direct services in terms of information and referral. For well over 20 years, the dual role of service provider and advocate was performed by the voluntary sector in the alcoholism field, and performed well.

Volunteers successfully advocated for the acceptance of the disease concept of alcoholism by both the American Medical Association and the World Health Organization, with concomitant acceptance by other organizations. In addition, the voluntary sector advocated long and hard, at both the State and National levels, for the recognition of alcoholism as a major public health responsibility. In 1970, establishment of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) by Congress was a signal victory for the volunteer, and the beginning of a period of redefinition and redirection for the field.

The advent of public dollars completely changed the complexion of the alcoholism field and the position of the players. What had been a unique health issue, largely the concern of a few isolated treatment agencies in private hands and heavily dependent upon self-help and volunteer initiative, suddenly was a major public health issue with public dollars flowing into it. The NIAAA became the leader of the field and set priorities by virtue of its funding ability. The first priority was to treat the sick by developing treatment facilities and modalities. The field witnessed an influx of professionals—caregivers and managers alike—who focused on providing services to those in need. The volunteers who had enjoyed such prominence and success as advocates and educators as well as caregivers appeared to have little relevance to the new health science that was developing.

The influx of public dollars supported the development of networks of treatment services in almost every State of the Nation, and tasks that volunteers once performed now were performed for pay. The alcohol field had come of age, and the role of the volunteer was largely overlooked.

In the closing years of the 1970s, this situation began to change. Some scholars have suggested that a general ennui had developed among most Americans regarding their roles as citizens in a democracy.

There was a resurgence of voluntarism in America. Individuals once again began to direct their own destinies and the allocation of their tax dollars. It is estimated that in 1974 nearly one-fourth of the American population was donating volunteer time. Whether the cause was the Viet Nam War, Watergate, or the increasing depersonalization of government and business, Americans began to feel alienated from their own society, and distrustful of and disillusioned with the processes of that society. Dissatisfied with their relative inability to control national events, they began to take a more active role in local events.

This trend was given impetus by governmental actions during the same period. On State and Federal levels, laws were enacted giving legal status to volunteers. Tax deductions were allowed for expenses incurred in voluntary activities. Workmen's compensation laws were expanded to include volunteers. The citizen volunteer's role was emphasized with the passage of P.L. 93-461, which mandated strong consumer involvement in the development of State and local health plans. The law put great control in the hands of volunteer-dominated health planning boards.

By 1980, voluntarism was enjoying a resurgence. Further it appeared that a new kind of volunteer was being attracted to the alcohol field. In contrast with the volunteer drawn by a desire to directly aid alcoholics and their families, this newer volunteer wanted to be heard in matters related to the allocation of tax dollars and the provision of services to address a broader spectrum of needs. While historical factors have shaped the volunteer movement today, there are emerging factors that will shape the volunteer role in the latter half of this decade.

Rise of Consumerism

Our ability to provide a new, more substantive role for the volunteer will have a great impact

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Managing A Volunteer Program: Challenges and Rewards

William Uebelher

Challenges and rewards: there are plenty of both for the program director or staff member who works with volunteers. The Alcoholism Council of Colorado (ACC), the State affiliate of the National Council on Alcoholism, is basically a network of volunteer task forces and committees conducting a wide range of education, information, awareness, and prevention activities. The ACC has also been a participant in the Volunteer Resource Development Program (VRDP), receiving support from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) designed to stimulate voluntarism throughout Colorado.

VRDP, the name NIAAA gives to organizations like the one I serve, is a good acronym, lending itself to a variety of characterizations of the many volunteers who are the heart and soul of such organizations. VRDP means Volunteers Really Do Produce results or Volunteers Really Do Pack a wallop, or Volunteers Richly Deserve Praise. And then there are other times when it means Volunteers Really Do Procrastinate or Volunteers Rarely Deliver Promises. I'm glad to say that the former far outnumber the latter; but the latter are the proverbial "squeaky wheel."

The Role of the ACC

Volunteers are the heart and hands of the ACC. As with other NCA affiliates, our organization consists of a small paid staff of

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Volunteering: Challenges and Rewards

Elise Willson

O'Leerie, I'll go round at night
and light the lamps with you.
Robert Louis Stevenson

As a small child, I remember hearing these words read to me from Robert Louis Stevenson's *Lamplighters* and thinking that one day I would be a lamplighter, a volunteer. The dictionary describes a volunteer as one who enters into or offers himself or herself for a service of his or her own free will. The legal definition is "of voluntary acting of one's own free will without valuable consideration or legal obligation."

On his visit to America in the early 1800s, Alexis De Tocqueville, author of *Democracy in America*, wrote of his admiration for the skill with which individuals in the United States succeed in proposing a common objective for the exertions of many and inducing them voluntarily to pursue it. He went on to say that, in American life at that time, the volunteer sector was more important than government or business.

Today, to call someone a volunteer sometimes has something of a negative connotation—"a person who doesn't get paid," "a nonprofessional," or perhaps "a nuisance." Yet as Thomas P. Pike, director emeritus of the Fluor Corporation and himself an outstanding volunteer in the field of alcoholism, has said, "I am deeply convinced that volunteer work is a two-way street which can be highly beneficial to the person performing it as well as to the one being helped."[1]

Sarah Jane Rehnborg, president of the Association for Volunteer Administration, says volunteering is an exchange, not a gift, and perhaps that is the answer to the motivation of volunteering. As a volunteer, there may be more of an opportunity to live up to one's potential or be self-actualized—a term developed by Abraham Maslow. Maslow describes a hierarchy of needs that begins with food and shelter, rises through security, friendship, and esteem and culminates in self-actualization. Although the workplace and the jobs in today's factories and shops are usually less stultifying and provide greater job satisfaction than they did years ago, there is not always the opportunity for many people to grow to their greatest potential with rewards based on their contribution of knowledge and skills.

I have been volunteering all of my life. Now, in my seventh decade, I am still finding that the lamplighter has many lamps to light and that the challenges and the rewards are there. One of the most satisfying periods in my weekly schedule is the 4 hours I spend on a local National Council on Alcoholism (NCA) helpline. There, I have the opportunity to call into use all of my lifetime of professional and personal experience.

Currently, about 40 volunteers staff the helpline, answering calls from alcoholics and their families. The volunteer acts as an intermediary, helping ease callers through crisis situations and referring them to appropriate community treatment resources. Basically, we give peo-

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[1]Speech made on May 29, 1981, in Denver, Colorado, on "The Future for Volunteerism in the Field of Alcoholism."

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The Fundraising Potential Of Volunteers

William Butynski, Ph.D.

Volunteers have played a significant role in the alcoholism field for many years. However, their role is currently undergoing some important changes. In the past, volunteers were often helpful primarily in supplementing staff services, in lending their name and credibility to the boards of directors of alcoholism programs, and in setting overall policy directions for these programs. The staff then worked to carry out board policies and often assumed the primary responsibility for raising monies to support the program through writing grant applications for Federal, State, and local funds. Today, one major source of financial support, the Federal grant program of the National Institute on Alcohol Abuse and Alcoholism, no longer exists (except for the research and training areas). These monies have been cut by 25 percent and then transferred through the block grant mechanism to States. State governments now have great flexibility as to the distribution of these funds, including choice of dispersal mechanisms (grant, contract, fee for unit of service) and recipients.

Many nonprofit alcoholism programs previously supported by Federal grants may not survive the transition of monies and decisionmaking authority to States. Other programs, those that work to build on and enhance the contributions of volunteers on their boards, on their committees, and in other roles, may thrive and grow. This article offers some initial suggestions to assist those in alcoholism programs who wish to boost the fundraising potential of volunteers.

The "How-Tos" of Fundraising: Why Volunteers Are Essential

Today, it is more important than ever for alcoholism programs to become independent of government support and to seek monies from private sources. Those private sources that are growing in significance include individuals, corporations, and foundations. To obtain monies from these private sources, the involvement of volunteers is critical, because volunteers can provide the personal contacts necessary to effectively raise monies from these new sources of support.

The keys to effective fundraising from private sources include the following steps.

Determine the needs and describe program objectives in clear, concrete, persuasive, and measurable terms. This step is similar to the process of needs definition and program specification engaged in earlier by many program staff in developing grant applications. The major difference is that members of the program's board of directors should be more actively included in the development process and the outcome should be a fairly short "case" statement of 1 to several pages rather than a lengthly proposal of 50 to 150 pages.

Acquire a basic knowledge of the variety of available fundraising sources and fundraising techniques. This is likely to be a challenging educational process for both board members and staff.

Make decisions about which funding sources to pursue and which fundraising techniques to use. This step may include a decision for staff to continue to pursue grants from State and local government sources, but it is also likely to include a decision for board members and other volunteers to pursue additional sources of funds including individuals, corporations, and foundations. The involvement of influential volunteers is essential for success in the pursuit of monies from private sources, be it through solicitation of individuals or the submission of funding requests to corporate executives or foundation boards of directors.

Select, recruit, and orient the leadership for the fundraising campaign. The choice of the fundraising campaign chairperson and fundraising committee members is crucial to the success or failure of the campaign. The

individual selected as chairperson must not only be committed to the cause (the particular alcoholism program), but also must have extensive personal community contacts with persons who are wealthy themselves or who have access to wealth through corporations, banks, and foundations. Although generalization is dangerous, often the best choice is an aggressive businessperson who has prior experience managing fundraising campaigns. This chairperson must then be given a fairly free hand to choose other members of the fundraising committee.

Develop a detailed fundraising plan and strategy. This step should include substantial support work by staff and possibly the inclusion of special fund development consultants, but key fundraising committee and board members must also be involved. Such involvement by committee and board members will not only make use of their special contacts, knowledge, and experience, but also ensure that they are fully committed to the fundraising plan.

Provide staff, board, and fundraising committee support to volunteer solicitors. The staff must develop and provide support ranging from research on prospects, to publicity, to materials such as a case statement, pledge cards, and thank you letters. The board members must demonstrate their commitment through 100 percent giving of a generous nature in proportion to their means and the program need. The fundraising chairperson and committee members must demonstrate leadership in their attitude, enthusiasm, giving practices, and successful solicitation of others. Finally, appropriate training (for example, role playing of prospective solicitation situations) and a reasonable schedule should be developed and reasonable demands should be placed on all volunteers. For example, those individuals soliciting major gifts each should be asked to solicit such gifts from only three to five of their peers, although those gifts should be substantial in nature and the calls should be made in person. People give for a variety of reasons, but a primary one usually is that they have high regard for and confidence in the "asker" as an individual whose judgment they respect.

Provide appropriate followup and thank yous to all donors. Staff must provide appropriate records and a "tickler" system to ensure that all calls to prospective donors are made and necessary followup reminders provided if decisions on contributions are delayed. Volunteers must maintain their lead role by making all followup contacts with prospects in face-to-face meetings. Also, the volunteers and the organization's board of directors must acknowledge all gifts. The volunteers should not only verbally thank the donor but also should send a personal thank-you letter. In addition, the fundraising campaign chairperson and board of directors should provide appropriate thank yous (a plaque or certificate of recognition; publicity, if desired by the donor; and letters of thanks from service recipients of the program). Such concrete actions not only express appreciation in appropriate ways for the gift made, but also serve to promote the program's overall goal of increasing continuing support through repeated (at least annual) contributions in future years.

The primary reason volunteers are essential for fundraising campaigns is that, to raise monies most effectively, the person asking for funds should be committed to the cause while (as differentiated from staff) not receiving any financial gain from the contribution.

Successful Fundraising by Alcoholism Programs

A number of alcoholism programs have been successful in working with volunteers to raise monies. Most, if not all, of these programs view volunteers as essential not only for contributing and soliciting funds but also for providing significant and ongoing leadership in program policies and directions.

Chit Chat Foundation is an alcoholism treatment program based in Wernersville, Pennsylvania, that recently undertook a major capital campaign to add a second treatment facility to their program. Within a moderately industrialized county of approximately 300,000 persons, they raised over $600,000 within a 4-month active solicitation period. Also, they solicited and obtained a $100,000 challenge grant from the Kresge Foundation. The Executive Director of Chit Chat, Richard W. Esterly, attributes these successes to selection and use of outstanding volunteers. Although he acknowledges that his staff provides research, coordination, and other support, he states that, once the initial core leadership group of volunteer fund raisers was identified, they proceeded to build their own base of volunteer contributors and solicitors who successfully

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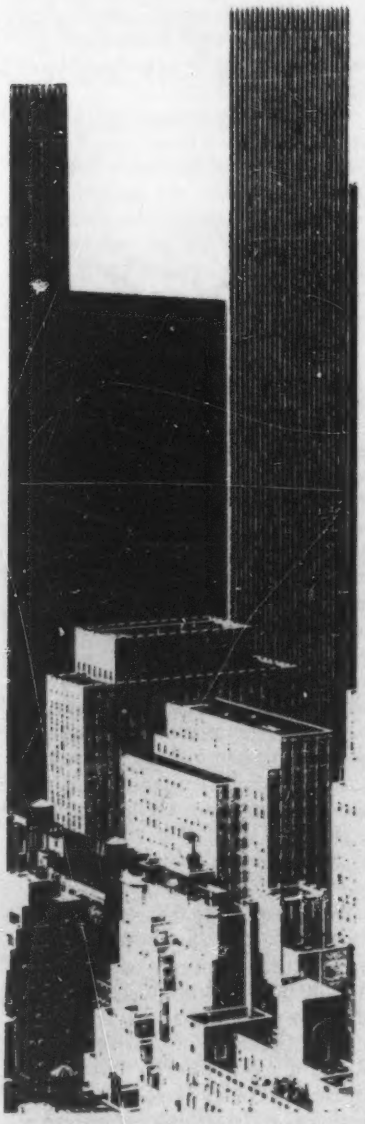

Reaching Out to the Corporate Community

Judy L. Vaughn

Voluntarism may become the new buzzword of the 1980s as society struggles harder to maintain public services at acceptable levels. Money has become increasingly scarce as inflation takes its toll, and the shift of responsibility for social programs from the public to the private sector seriously threatens the financial stability of many programs. Volunteers have always played a role in such programs in America. But today we are experiencing a vital need for volunteers to play a strong role in maintaining human services at an acceptable level—by providing advocacy for including altruistic goals in a public sector priority setting, by serving as professional service extenders, and by continuing to add the hallmark of humanism that is expected from social programs.

Volunteers made a significant contribution to the expansion of community resources in the 1970s through fundraising, education, and other activities that support human service programs. Local, State, and National networks of volunteer resources have been established. As we enter an era in which social responsibility reverts from the public sector to the private sector, it is evident that there are too many hands out for a very limited quantity of private benevolence —both financial support and service support. We are faced with a twofold task: to build funding support to continue program activities and to develop an ever-larger cadre of volunteers to perform the needed services. The private sector, especially corporations and business, is a potential source for both. In addition to increasing efforts to develop corporate contributions of money, we should also be pursuing ways to tap businesses as a resource for volunteer staffing of social service programs.

Traditionally, corporate support has been primarily financial. Alcohol programs are in for hard times under current criteria for corporate support. Alcoholics aren't as appealing as blind children. Effective prevention results aren't as visible as subsidizing a Shakespeare festival or a race. All too often, we in alcohol programs over-emphasize the problem instead of the wonderment of recovery, and haven't effectively conveyed the message that funding for alcohol education and prevention can actually be a good investment. Knowledge that treating alcoholism lowers accidents and crime rates and reduces absenteeism while increasing productivity is a great motivator for companies to look at employee assistance programs; it may also be a good reason for making a contribution toward building awareness about alcoholism in the community.

While we can improve our track record in raising money, fundraising as we know it today isn't going to pave the way to survival. Certainly there will be some corporations which will meet their self-appraised community citizenship obligations by writing a few checks, just as some members of the agency's voluntary board of directors who don't come to meetings or serve on committees will send an end-of-the-year contribution.

However, it may be that a different approach to the problem is needed—an alternative to putting our hands out for a cash contribution with no effort to discern the "personality" of a company and develop suggestions for ways it can contribute that are most appropriate for its resources. Perhaps a key to what makes a corporation respond is the

recognition that the decision process in this seemingly inanimate entity is still in the hands of an individual or several individuals, who will or will not feel rewarded by the outcome of a decision to participate. We have to do our homework, to make sure we can provide a business with a "payoff" for supporting our programs, and we must broaden our view of corporate contributions beyond just that check. Perhaps it might be worthwhile to learn how to ask for a service—one of the products of a well-managed industry—as well as for dollars. For example, when we approach business with our hands out for a cash contribution to print materials, but don't find out that the corporation has its own inhouse printing service that might have accommodated a request from us and more, we haven't done our homework.

Can the volunteer force consider among its membership a business entity as well as an individual? Therein may rest the solution to the extreme demands that are being made upon voluntarism. Perhaps simply asking for money belittles and devalues the potential contribution of a corporation as well as of an individual. Learning how to ask for service may prove to provide the impetus that alcoholism volunteer programs need to meet the future.

Some charitable organizations across the country already have made exceptionally good use of the barter-service system in executive loan programs. It's not off target to suggest that a corporate entity might be favorably disposed to use its expertise and to share some of its staff resources with an agency devoted to volunteer efforts centered on alcoholism. It makes more sense than expecting that company to respond to a letter or to a knock on the door by someone representing an alcoholism treatment agency, and solely on the basis of altruism, to write a check sufficient for your needs.

In return for contributions of corporate volunteers, the agency can provide many valuable services to business. Most important, perhaps, it can offer itself as a management training ground. The administrative demands in a voluntary agency, charged with accomplishing multiple objectives within a minimal budget, can be considerably more challenging than the normal challenges of the business world. Priority establishment, cost-effective planning, time management, and decisionmaking are administrative skills that effective volunteers learn to use.

The volunteer sector is fueled with the stuff that can mold diplomats from the rawest of materials. In the workplace, there is remuneration for service—salary, wages, or commissions, but that leverage is not available in managing volunteers. How do you "fire" or otherwise neutralize an ardent volunteer whose style has negative effects on other volunteers? Only in the volunteer sector does so much depend on individual strengths and weaknesses and the continued weighing of options to ensure continued effective efforts from all involved.

Sometimes neither the agency executive director nor the existing volunteer staff is knowledgeable about how to provide something of value to a business. Then perhaps the best approach is to secure an executive expert from the company to help delineate possible marketable services. For example, someone from research and development might help the agency use brainstorming and other creative problem-solving methods to come up with new services. A marketing staff representative might help agency personnel learn more about the competition and how to make the hoped-for exchanges of services.

If asking for this kind of help is threatening because the agency staff fear that no services of benefit to the company might be identified or that a new service area might be required, it is possible that the agency really has no reason for existing and, thus, no justification for seeking financial support in hard times. If that evaluation seems harsh, consider that social programs should be designed to meet society's needs, and society, like the "enemy," is us, once we've met it!

If we complement the volunteer force by recruitment of corporate volunteers—from companies who have very specific skills or who possess staff with expertise—our areas of service will be broadened considerably by committed experts, who will ask nothing less of our agencies than that they be responsive to their perceptions of society's needs. Our agencies in turn will begin to build the skills that will be of exchange value to other companies for money and services.

It is obvious that an exchange of services will not meet all agency demands—dollars are still necessary. The services the agency develops with corporate volunteers will, however, encourage development of new revenue sources as well as help to recruit more volunteers. Development of a small cadre of committed corporate volunteers who become familiar with your servi-

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Judy L. Vaughn is a volunteer with the Alcoholism Council of Colorado in Denver, Colorado.

Voluntary Business Groups: A Resource for Small Business EAPs

John McGrath, M.A., Staff Writer

Small businesses occupy a unique position in this nation's folklore and economy. From the family farms to the cottage industries to the bicycle shops to the tractor dealerships, small businesses have been the source of inspiration for paintings, songs, short stories, and plays for the past 200 years. But small businesses are not simply part of our past, frozen forever in a Currier and Ives time capsule; they are part of our present. The independent butcher and baker and candlestick maker are very much alive and well, thank you, and are in fact thriving in revitalized downtown malls, suburban shopping centers, and midtown store fronts. And they are neighbors to hundreds of similar small businesses located throughout the community: the tool and die shop, the insurance agency, the corner garage, and the hardware store.

Although individually these businesses may be small in their number of employees and their gross receipts, collectively they are anything but small and they exert a major force in the country's economy. A few national statistics provide a fascinating insight into how big small business really is.

According to the Small Business Administration, small businesses represent 43 percent of the total U.S. economy. Of the 4.1 million business establishments in the United States, 78 percent employ fewer than 10 individuals. Nearly half of the total gross national product (GNP) contributed by all business comes from small businesses.

But these statistics don't paint the whole picture of the role of small business in the life of a community. Small businesses are the veins and arteries that keep the goods and services and money in a community circulating. If the businesses prosper, the community prospers. If the businesses develop problems, these problems can eventually affect the economic and social health of the community.

For this reason, many volunteer organizations that represent business interests—such as the local chamber of commerce, the board of trade, and business and merchant organizations—have taken an interest in fostering programs that promote the health and welfare of employees of small businesses.

Volunteer activities may conjure up images of candystripers rather than pinstripers. But voluntary organizations representing business interests are taking an increasing interest in employee assistance programs (EAPs), and their interest is based on some straightforward business logic: employee assistance programs are good for individuals, good for the community, and in the long run, good for business.

The role that business organizations play in developing an EAP can vary from simply handing out information to actually establishing the program. Three typical levels of involvement illustrate how a business organization can provide a service to its members by fostering the development of an employee assistance program. All three approaches have one thing in common. They represent the consortium approach to EAPs. In the behavioral health field, the word consortium has been loosely applied to any staffing pattern in which a number of work organizations are serviced by an outside group of persons.[1]

Three Approaches

In the first of the approaches, a voluntary business organization might sponsor an event at which all service providers in the community are invited to exhibit and discuss their services. In this instance, the role of the business organization is limited to bringing the service providers and the service users—the small business—together on a one-time basis and then stepping out of the picture. In essence, the business organization sponsors the event, provides the introduction, and allows the marketplace to take over.

The second approach involves a more active commitment on the part of the volunteer organization. In this instance, the business organization establishes itself as a permanent, direct link between the service provider and

[1]Presnall Lewis, Occupational Counseling and Referral Systems. Utah Alcoholism Foundation, Salt Lake City, 1981.

the small business. Any time a small business wishes to get an employee into counseling or treatment, the referral to a local service provider is made through the voluntary business organization. The organization assumes a greater responsibility in this case. In order to provide an effective service, at least one person in the organization must have a background in EAPs and be knowledgeable about the various services available in the community.

The third approach represents the voluntary business organization's highest level of involvement in and long-term commitment to EAP development. In this instance, the organization establishes a freestanding independent assessment and referral service for all the small businesses that are members of the organization. The actual treatment is given by community service providers, but the business organization hires a full time, professionally trained staff person who offers assessment and referral services. In addition, this person usually provides supervisor and employee training as well as educational material to participating companies.

Practical Application

The concept of EAP development by a voluntary business group is not untested. In three communities, the local business organization has successfully supported EAP development for its small business members.

In Taunton, Massachusetts, the Chamber of Commerce introduced the concept of a chamber-sponsored employee assistance program at one of their meetings in 1974. The response of the small- and medium-sized businesses in the area was encouraging. Within 1 year, 16 firms with a total of 7,834 employees were affiliated with the program. The chamber contracted with the Boston College School of Social Work to provide professional staff support to the program. The program is still in operation, a testimony to the service it is providing the small businesses in the Taunton area.

Another employee assistance program was initiated by the Albuquerque, New Mexico, Chamber of Commerce with a NIAAA grant. In this case, the target group for EAP services were small businesses with fewer than 100 employees. The project staff, hired by the chamber, provided supervisory training to participating companies in the early days of the project. The essential services provided by the staff were an assessment of the employee's problem(s), an identification of appropriate and available community resources, active referral to a community treatment facility or church, and followup services to monitor the progress of the client.

In Baltimore, Maryland, the Greater Baltimore Committee (GBC) serves as the city's major business organization. In 1979, GBC initiated a program to assist business and industry in Baltimore to cope with the problem of alcoholism among their personnel. GBC offers two types of services to its members.

Those companies with sufficient size to justify a continuing program on an in-house basis are provided with a consultation leading to the establishment of a written proposal for the in-house program and a periodic evaluation after it has been established. On a fee-for-service basis, smaller companies can arrange for GBC's assistance in structuring personnel policies and tailoring programs appropriate to their special needs. Individual counseling and referral services are available to employers, employees, and their families.

Assessment of Need

A voluntary business organization considering one of the above options or a combination of those options should take a few preliminary steps to determine which will be most useful to its members.

The first step, of course, is a needs assessment. One part of this is an assessment of the perceived need for an EAP among the organization's small business members. Do the top managers recognize that some employees need assistance? Are they ready to commit funds and resources to a program? Do they need to be cultivated or sold on the concept of an EAP?

A second aspect is an assessment of the treatment services available in the community. Can the network of treatment facilities in the community handle an increased caseload?

In order to sustain a full-fledged EAP program (the third approach described above), a business organization will need the moral and financial support of the management of the small companies. Consortiums, on which this approach is based, have usually charged participating companies a fixed annual fee ($500, for example), plus an additional fee for each employee in the company ($1.50, for example).

If the needs assessment reveals that there is substantial support as well as a perceived need among small businesses, the business organization may wish to assume an active role in the establishment of an EAP. □

The Cottage Program: Volunteers In Prevention

Bernell H. Boswell and Robert K. Boswell

When we knocked on the first door, we were armed with little more than a deep social consciousness of the human tragedy of alcoholism. We were convinced that treatment alone was not sufficient. The Cottage Program in Salt Lake City, Utah, was grounded in both a practical and a theoretical commitment to prevention. Employing several unique methodologies and techniques to reduce the incidence of alcohol abuse, the program sought to help change the patterns of behavior in the lives of people long before there was a need for treatment.

The Cottage Program was launched as an experimental pilot program in alcohol education in February 1972. It was founded on the challenging premise that concerned and interested citizens, volunteering their time and efforts, could reach out in their neighborhoods in an education and prevention program to alleviate problems related to alcohol.

The target of the Cottage Program is the total community—not just those personally affected by alcohol misuse and alcoholism. Cottage meetings seek to educate the general population concerning the ways in which patterns of interaction in the family and with significant others can promote or prevent alcohol problems.

While the Cottage Program was initiated as a method of bringing education and awareness of alcoholism to the general population, it also reaches individuals and families with alcohol-related problems. In these cases, the Cottage Program helps the family learn more appropriate responses to the alcohol problem. Children living in the high-risk environment are exposed to a constructive learning process, an important element in minimizing future alcohol problems among this group.

The Cottage Meeting Process

The Cottage meeting is a small informal gathering of individuals to discuss alcohol use and problems. Meetings may be held in homes, schools, community organizations, or industrial settings. Cottage meeting hosts are identified and recruited through several means: the primary method involves Cottage volunteers going door-to-door in an effort to inform their neighbors of their concerns about the negative effects alcohol misuse may have on families and on the community in general. Meetings are also set up in response to calls from families in which there is a problem drinker or as a result of presentations of the Cottage concept at business, civic organization, church, or community meetings.

Trained volunteers not only recruit meeting hosts but also function as group moderators in Cottage meetings, working in pairs as a team. Usually, two meetings with the same group are scheduled, held 1 week apart. While the meetings are educational in focus, occasionally someone will request help with a personal or family alcohol problem; in these instances, the volunteer moderators are prepared to provide a referral to a professional alcoholism counselor, a highly skilled therapeutic volunteer, or an outside treatment agency.

Volunteer Training Programs

The Cottage Program is built on the talents and contributions of volunteers. And training is an essential, ongoing element of the program.

Sources for recruiting volunteers are virtually unlimited. In Salt Lake City, many volunteers come from churches, schools, and industry. The Cottage Program is an ideal project for active church members, and clergy who have to deal with alcohol problems in pastoral counseling are eager to encourage members of their congregation to become involved. Business managers, who see the effects of alcohol problems in their work force are also supportive of employee involvement in the Cottage Program. University students, particularly psychology and sociology students, may receive credit for participation in the program, and

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Bernell N. Boswell is the founder and executive director of The Cottage Program, Salt Lake City, Utah. He also serves as director of the Utah Volunteer Resources Development Program. Robert H. Boswell has been associated with the Cottage Program since its inception.

VOLUNTEERS STAFF HOTLINES

The use of volunteers to staff telephone hotlines for alcoholics and their families has paid handsome dividends to programs in New Jersey and the District of Columbia. Although the programs have used different approaches to the training and assignment of volunteers, both the ALA-CALL hotline in Cherry Hill, New Jersey, and the Washington Area Council on Alcoholism and Drug Abuse (WACADA) hotline in Washington (DC), have been able to enhance their operations through the use of volunteers.

According to its director, ALA-CALL might never even have been established were it not for volunteers. "To this day, I'm convinced that the State gave us the contract for the hotline because we had 200 volunteers trained and ready for work," says director Elinor Doyle. "We already had the office space (a crisis intervention hotline for Camden County residents was already in operation), and all the State had to pay for was clerical support and a statewide toll-free number. The volunteers were recruited, trained, and ready to go to work."

Both the Camden County and the statewide hotlines had been staffed from the very beginning by volunteers. "Our people are dedicated and feel they are really making a contribution."

Doyle attributes this enthusiasm to the extensive training that the volunteers receive. Potential volunteers make a $25 donation to cover expenses and attend training sessions 1 night a week for 13 weeks. Volunteers then observe the hotline operation for 10 hours. After that, each volunteer puts in six 4-hour "apprentice shifts," during which he or she talks to callers while a more experienced volunteer monitors the call. Finally, a volunteer can work the phone unassisted.

Doyle believes this rigorous training works to encourage volunteers. "They feel it is important and, since our lines are open 24 hours a day and 365 days a year, volunteers know that if they don't show up, someone else will have to stay longer," Doyle says. "We ask people to make a commitment. And since we get a lot of calls on weekends and in the evening when other services may be closed, we find that people rely on us. Often, we're the only help there is."

According to Doyle, ALA-CALL receives an average of 80 calls per day and will have logged more than 28,000 calls in 1981. ALA-CALL has been in operation since 1973.

The WACADA hotline began a year later and uses far fewer volunteers—only 12 at the present time. But their impact has been significant, according to Volunteer Coordinator James Norris. "The most important benefit for us is that volunteers have enabled us to get other projects done. For example, I do outreach work in the evenings, and now I can go out and recruit new people, knowing that there are enough trained volunteers to handle the hotline and other services."

The WACADA hotline is also in operation 24 hours a day and volunteers undergo screening before training program begins. WACADA's bimonthly training programs include sessions on basic communication skills, values clarification, sensitivity training, alcohol problems and alcoholism, plus on-the-job training on the hotline. After training, volunteers begin assisting staff on the hotline and then are phased into the hotline operation. Professional staff are always on duty, however.

The challenges that arise with volunteers, Norris says, include shift staffing and maintaining volunteers' enthusiasm. "You have to remember you can't demand that volunteers come in at 2 a.m. like paid staff. Volunteers' time is their own, so you have to work around that." Also, he says, once you train volunteers, you have to work hard to keep them interested. "A lot of people will come in to your organization on the spur of the moment. They'll be very enthusiastic at first, but then they'll lose their excitement. You have to work to counteract that."

Both hotlines have been successful in recruiting and retaining volunteers. They offer a service that otherwise would not be available, by making effective use of volunteers. For further informaiton contact Elinor Doyle, ALA-CALL, 1051 N. Kings Highway, Cherry Hill, NJ 08034 and James Norris, WACADA, 1221 Massachusetts Ave., NW, Washington, DC 20005. □

—John Small, Staff Writer

The President's Task Force To Identify Effective Volunteer Models

In October 1981 President Reagan signed an Executive Order establishing the President's Task Force on Private Sector Initiatives. The establishment of the Task Force was the most visible in a series of actions the President has taken to encourage private citizens and organizations to volunteer their time, energy, and resources to public service programs.

"I have never found an agency, a program, a piece of legislation or a budget that was adequate to meet the total needs of human beings," the President said in remarks establishing the Task Force. "Something is missing from such an equation. I believe that something is private initiative and community involvement."

One of the main goals of the Task Force will be to identify existing examples of successful private initiatives and public/private partnerships and give these models national recognition. The Task Force feels this is the best way to promote the broader use of these models.

One such example is the Ronald McDonald Houses, located near children's hospitals, where families can stay while their children are treated for serious diseases. These homes are funded primarily by local McDonald operators and staffed by all volunteers. Coalitions of business people in several cities across the country provide another example. Each year, these coalitions find thousands of summer jobs for youths who would otherwise be unemployed. An association of 100 businesses and civic leaders in New York, the New York City Partnership, last year placed 14,000 mostly disadvantaged youths in summer jobs.

Another major goal of the Task Force is to identify government obstacles to private initiatives and to formulate incentives which encourage the private sector to undertake new initiatives. In discussing this aspect of the Task Force, President Reagan said he was instructing his Cabinet to review their agency's procedures and identify barriers to private sector involvement.

"We want to deregulate community service" the President said. "For example, mothers and grandmothers have been taking care of children for thousands of years without special college training. Why is it that certain States prohibit anyone without a college degree in early childhood education from operating a day-care facility?"

The chairman of the 44-member Task Force is C. William Verity, Jr., board chairman of Armco, Inc. Verity has served as the head of the U.S. Chamber of Commerce and is currently on its executive committee. Among other things, Verity hopes to encourage the broad use of a plan which his home town of Middletown, Ohio, adopted. In Middletown a group of businesses and civic and local government leaders identified several ways to cut back Federal aid to the town without eliminating essential services.

Verity said a prime benefit of the plan is realized "when you begin to build momentum and see an awful lot of things that don't have to be done by government." The Middletown Plan, he said, provides an opportunity for business to help local government leaders make the most effective use of available resources.

More information on the Task Force can be obtained directly from Patrick Butler, Task Force Director of Communications, at 734 Jackson Place, N.W., Washington, DC 20500.

John McGrath, Staff Writer

ELDERLY VOLUNTEERS RAISE ALCOHOL AWARENESS

The Community Alcohol Rehabilitation and Education Project in Naples, Florida, developed and implemented a 2-year plan that successfully recruited dozens of elderly residents to participate in alcoholism prevention projects.

The project was carried out in 1978 and 1979 by the David Lawrence Mental Health Center, a private, nonprofit organization in Naples. Carol Slauson, director of substance abuse services, needed volunteers to carry out prevention projects that had been drawn up by the center. The Naples Women's Club, a civic organization that had a long tradition of member involvement in community service activities, in 1978, decided to make alcohol education and prevention a 2-year project and suddenly the door was open for a variety of prevention projects in the Collier County area.

Taking advantage of this commitment of volunteer support, the mental health center staff developed a training program to prepare volunteers for a variety of outreach projects. Each volunteer was provided with 3 hours of training each week for 6 weeks, including roleplaying sessions during which volunteers could apply what they had learned.

The center staff invited television news crews, media representatives, county officials, local psychologists and psychiatrists, and well-known leaders of the Naples retirement community to a large orientation session. "We also sent letters to every civic group in town letting them know we had people available to give lectures and presentations to their members." Evaluation forms were distributed after each presentation, and Slauson said trained professionals were available to help with more technical questions or followups whenever needed.

During the 2 years, volunteers made presentations to dozens of groups in the Naples area. In addition, the Women's Club made donations of films and books on alcoholism, plus a projector and a screen to the center's library, and often supplemented their presentations with materials they had purchased themselves.

Slauson sees numerous advantages to using the elderly as volunteers. First, she says, they provide access to people that other groups or organizations might not be able to reach. "They had no problem getting into social groups, clubs, and civic organizations," Slauson said. Second, volunteers are usually doing something they choose to do, so they put a lot of time and energy into their work. Finally, she said, the "burnout" rate is lower than for staff members or others who are already working a 40-hour week. "Retired volunteers have plenty of free time," she said.

Slauson said the main problem that had to be overcome was transportation. "Some elderly people don't drive and others won't drive at night. And if you're in an area that doesn't have good bus service, it's an even bigger problem." Also, many elderly people are on fixed incomes and the cost of gasoline can sometimes be prohibitive.

In spite of these problems, Slauson said the project was a huge success. Elderly volunteers "can perform a variety of roles, but it is important in any project to match the right person with the right job," she said. "Most older people have always worked for a living so the idea is hardly new to them. Volunteer work is, in many ways, an extension of their former working life. And, of course, it makes people feel better and increases their self-worth." For more information, contact Carol Slauson, David Lawrence Mental Health Center, 6075 Golden Gate Parkway, Naples, FL 33999. □

—John Small, Staff Writer

Older Americans Volunteer in ACTION

Maysie Sayre was 72, with no one to cook or care for since her children had left home. She knew it was time to take action to revitalize her life. And at ACTION, headquarters for the Older American Volunteer Programs (OAVP), they were ready for Maysie Sayre.

Through its three components —the Senior Companion Program (SCP), the Foster Grandparent Program (FGP), and the Retired Senior Volunteer Program (RSVP)—the OAVP provides needed services to the Nation's population, while ensuring that the talents of the country's older citizens will not be overlooked. Sayre, now a volunteer Senior Companion to a bedridden elderly woman in Weston, West Virginia, explains that both parties benefit from the OAVP approach. "I enjoy this work," she says. "I'm happy for the first time since my children left home and I broke up housekeeping." Her client, Pauline Pritchard, is equally appreciative: "I don't want to go to a nursing home. I'm better off in my own home. And Maysie comes in every day, so I can stay here."

Maysie and Pauline's caring relationship reflects ACTION's policy of helping volunteers use their particular areas of expertise. Agency officials estimate that some 300,000 senior citizens currently serve as volunteers under the OAVP banner; most of them, like Maysie Sayre, use the experience gained through years of working and living to ease others' problems. For example, one senior volunteer who grew up in a bilingual household helps solve the problems of elderly immigrants who do not speak English. And a retired accountant uses his business knowledge to help his fellow senior citizens fill out tax forms and find safe, low-income housing.

This cooperative arrangement adds up to fulfilling lifestyles for everyone involved in the OAVP. Senior Companion Val Couglin explains, "The wonderful thing about this program is that volunteers like myself know and care, perhaps better than others could ever understand. Because, very simply, we are seniors ourselves."

Citizens in every age group benefit from the ACTION programs, however. In one community, an 84-year-old carpenter, an RSVP volunteer, brings the tools of his trade to third- and fourth-grade boys, teaching them how to make useful products in wood; in the process, he carves out a new and fulfilling life for himself. All over the country, children—ranging in age from preschoolers to teenagers—find that Foster Grandparents' hands, though perhaps wrinkled, are steadying, guiding ones.

In the future, older Americans will have an even greater role in helping young Americans: the OAVP's "hands-on" approach will serve as a model for other ACTION programs. ACTION Director Thomas W. Pauken states, "I want ACTION to apply to the potential and to the problems of youth the same effective and thoughtful program development that has made our OAVPs so successful and popular." While it is not yet clear what form these new programs will take, Pauken does indicate that he envisions using volunteers to deal with the problems of runaways, child abuse, and drug and alcohol problems in much the same way that the OAVPs confront community problems. In other words, citizens will be recruited to donate their talents and experience in community service, according to their skills and interests.

A 1977 OAVP survey revealed that RSVP volunteers had contributed 174,328 hours of service to agencies offering alcohol and drug services. These volunteers were involved in a wide range of activities including the following programs.

- *Education/Outreach.* Aurora, Indiana, is home to Seagrams and Schenley distilleries, and a host of alcohol problems. Fifteen older volunteers, working in conjunction with the local mental health center, constructed 50 display racks, filled them with alcoholism literature, and placed them in physicians' offices, banks, social service agencies,

the local hospital, schools, and laundromats.

- *Resource Development.* The same group of Aurora volunteers developed its own alcoholism literature. They filled 20 scrapbooks with newspaper and magazine articles on alcoholism, and provided them to libraries and mental health center branches where they are used by counselors. According to one OAVP official, the efforts of these RSVP volunteers represented "the first time that literature on alcoholism was available publicly in the community."
- *Counseling.* Volunteers in several communities established hotlines that operate 24 hours a day. Older volunteers answered questions on alcoholism and drug abuse, did intake counseling, and provided referrals to community service agencies. Some volunteers were recovering alcoholics; one such RSVP volunteer in Washington State concentrated specifically on counseling older people with alcohol problems.

A project in Kennewick, Washington, demonstrates that OVAP participation can strengthen voluntarism overall while tackling specific problems like alcoholism. The Juvenile Court of Benton and Franklin Counties in Washington refers young, first-time drunk driving offenders to Kennewick's RSVP project, where they assist older volunteers in community service projects such as yard work, window washing, and painting at public and private buildings. Some youths are assigned to nonprofit agencies—for example, Meals on Wheels—that provide services to senior citizens. More than 100 youngsters participate in this RSVP project each year, creating "an intergenerational interaction that is beneficial to both the younger and the older persons," and an atmosphere that stimulates voluntary participation by persons in all age groups, according to an ACTION official.

All Foster Grandparents (FGP) and Senior Companions (SCP) participants must undergo between 20 and 40 hours of orientation; in addition, they attend monthly training sessions. There are some material benefits for those who join the OAVPs—FGP and SCP participants receive a modest tax-free stipend to cover the costs of volunteering, a transportation allowance, hot meals during the hours they work, insurance coverage while they serve, and an annual physical examination. It is obvious, however, that personal gains keep volunteers in the program. Explains RSVP participant Tommy Thomas, age 80: "Volunteering is my way of keeping an old man active." Shannon Weller, age 71, says "You can't get rich doing this. But you get a lot more out of volunteer work than you'll ever have to give."

ACTION's OAVPs are an attractive invitation to volunteering. And as the number of volunteers serving as RSVPs, FGPs, and SCPs attests, Americans are responding with enthusiasm.

For more information about ACTION programs, call (800) 424-8580 or contact the regional ACTION office at the following addresses:

ACTION Region I
John W. McCormack Federal Building
441 Stuart Street, 9th Floor
Boston, MA 02116
(617) 223-4501
(Vermont, New Hampshire, Maine, Massachusetts, Rhode Island, and Connecticut)

ACTION Region II
26 Federal Plaza
Room 1611
New York, NY 10007
(212) 264-5710
(New York, New Jersey, Puerto Rico, and the Virgin Islands)

ACTION Region III
U.S. Custom House
2nd and Chestnut Streets
Room 108
Philadelphia, PA 19106
(215) 597-9972
(Pennsylvania, Delaware, Maryland, West Virginia, Virginia, Kentucky, Ohio, and the District of Columbia)

ACTION Region IV
101 Marietta Street, NW
Room 2524
Atlanta, GA 30303
(404) 242-2859
(Kentucky, Tennessee, North Carolina, South Carolina, Alabama, Mississippi, Georgia, and Florida)

ACTION Region V
10 W. Jackson Street
3rd Floor
Chicago, IL 60604
(312) 853-5107
(Minnesota, Wisconsin, Michigan, Illinois, Indiana, and Ohio)

ACTION Region VI
Old Main Post Office, Suite 301
Bryan and Ervay Streets
Dallas, TX 75221
(214) 767-9494
(New Mexico, Oklahoma, Missouri, Kansas, Texas, Arkansas, and Louisiana)

ACTION Region VII
Columbine Building, Room 201
1845 Sherman Street
Denver, CO 80203
(303) 837-2673
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ACTION Region VIII
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San Francisco, CA 94105
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(California, Nevada, Arizona, Hawaii, Guam, and American Samoa)

ACTION Region IX
1111 Third Avenue Building, Suite 330
Seattle, WA 98101
(206) 442-1558
(Washington, Oregon, Idaho, and Alaska)

—Jill Vejnoska, Staff Writer

When To Say "No" to an Interested Volunteer: The Screening Process

Lorraine Lafta

Editor's Note: The following article is excerpted from The Effective Coordination of Volunteers *published by the Department of Health and Human Services in 1978 and orginally produced under the auspices of the Domestic Violence Project Action Grant. The suggestions for volunteer screening in the article, directed to agencies that provide services to victims of domestic violence, also are applicable to programs serving alcoholics and their families.*

An agency's primary responsibility and goal is to offer responsive and competent services to clients. In addition to the disservice an agency would be doing to its clients by using inappropriate volunteers, a bad experience would hurt the volunteer, too. To help make determinations about the appropriateness of a would-be volunteer, screening procedures can help. The interview is the most commonly used screening technique.

Preparation for the Interview

Before the interview begins, it is a good idea to let the interviewee know how many positions are open, how the selection process will be conducted, how long the interview will last, and when and how he or she will be notified about final selections. When scheduling a screening interview, be certain to give yourself enough time to conduct the interview properly. A 15-minute break between interviews is essential to getting a well-rounded impression of the applicant. You won't have to rush through the interview, possibly overlooking important areas of concern. A break will also ensure that impressions do not "carry over" from one applicant to another, and will give you a breather. You also eliminate the possibility of keeping the next applicant waiting if your interview should run over.

Content of Interview

The interview should provide information about the organization: its philosophy and its goals. It is a time to share not only the exciting and positive aspects of your program but also the frustrations, failures, and emotional strains that are inherent in social service work. Allow time during the interview to acquaint the prospective volunteer with the activities and goals of your project. Prepare a written summary of project information that can be given to the prospective volunteer, and be prepared to answer questions and to supplement the written information with personal observations and experiences.

Be honest with the prospective volunteer about the less attractive aspects of your program. If clerical tasks are required, tell the prospective volunteer about them. It is better to lose a volunteer during the selection process, while there is still time to recruit others, than to use your agency's resources to train a volunteer who might not stay with your program.

The interview should help the agency staff assess whether the prospective volunteer has the personal qualities needed to work at the agency. There are, of course, general questions that are asked of any interviewee, such as age, education background, previous volunteer experience, and past and present work experience. Remember that your agency will be best served by volunteers who have an understanding of and sensitivity to relevant problems and issues. For example, if your agency deals with alcoholism,

you won't want a volunteer who perceives all alcoholics as degenerates. It should be a goal of the interview to reveal any such prejudices.

The interviewer should question the prospective volunteer about his or her sensitivity toward the clients' problems. During the Domestic Violence Project (DVP) interview we ask the prospective volunteer, "Why do you think a battered woman stays with a battering husband?" The volunteer's answer can tell a great deal about his or her awareness of the dynamics of family violence.

Questions also should be asked during the interview that specifically pertain to the roles which volunteers are needed to fill. Since sensitivity, empathy, and flexibility are essential, make sure you have questions that will give you some sense of the prospective volunteer's potential to develop such qualities. A good way of doing this is to construct a hypothetical situation to which the volunteer is asked to react. The volunteer's answer allows the interviewer to gauge his or her ability to deal with a typical agency situation and his or her ability to think under pressure.

Structuring Questions

Although knowing *what* to ask is important, knowing *how* to ask it is just as crucial. The DVP uses a question and answer format; if your agency chooses that format, be aware of what types of questions will best serve your needs. The two most common types of questions used are closed-ended and open-ended. A closed-ended question must receive a yes or no answer. This kind of question can be limiting, because one does not get the interviewee's perception. Asking closed-ended questions during the interview also does not enable the volunteer coordinator to find out how potential volunteers express themselves under pressure. Of course there are some circumstances where a closed-ended question is perfectly appropriate. "Do you have a car?" can't be phrased any other way.

Open-ended questions allow the person being questioned to explain his or her feelings about the focus of the agency. They also help the interviewer assess the skills the potential volunteer can bring to the program. Does the volunteer project a confident self-image? Is he or she able to relate well to people? Is he or she warm, sensitive, and caring? The nature of open-ended questions also allows prospective volunteers to feel that they are actively contributing to the interview.

All potential DVP volunteers complete a written questionnaire that asks for information about previous work and volunteer experience; previous training in connection with volunteer work; period of time of the commitment; and access to transportation. In addition, volunteers are asked why they want to volunteer for the program; and to evaluate their strengths and weakness as helpers. They must answer an open-ended question directed to uncovering their attitudes toward clients, and an open-ended question to determine their reception of the organizations' services. And they are asked to respond to a hypothetical situation; they are given about 5 minutes to respond in writing.

Conducting the Interview

One of the most difficult aspects of interviewing is learning to resist the urge to do a great deal of talking. The persons you will be interviewing will probably be nervous and uncomfortable. Your natural reaction may be to talk in an effort to put them at ease. Resist this impulse. If the interviewer is doing most of the talking, the interviewees are not going to generate enough information upon which to base a reasonable decision about their suitability to the agency. In addition, the potential volunteer may need a few moments of silence to think through what he or she would like to say. You may do a real disservice to the applicant if you try to fill in these "lulls" in the interview.

The team interviewing approach minimizes the difficulty of notetaking, but if you do not have the option of using team interviewing, notetaking may be made more comfortable by asking the person if he or she minds you taking notes. Explain the reasons for it. People (including interviewers) sometimes feel more comfortable acknowledging that a situation is uncomfortable. After doing a few interviews, you may find people give many similar answers. You could make up a key, using a few code words that will represent the stock answer. You might tape the interview. Be sure to ask the volunteer's permission before you do so, however. Also, make sure that you save all the notes you make on each volunteer, to help you in the selection process. In addition, you may want to use the notes when explaining to a volunteer why she or he was not selected.

Making An Assessment

Once the interviewer has gathered information, both factual and subjective, a points system can be used to assign a number value to each of the qualities you desire in a volunteer. If you have structured your interview properly, determining

Continued from page 25

your number value should not be difficult. The points system should be finalized before interviewing begins, as it will provide you with an equitable process for determining who are the best qualified applicants of the group. The DVP rates potential volunteers on a scale of 0 to 10 points in the following areas: experience, personal dynamics, grasp of ideas, time commitment, access to transportation, and understanding of client and agency needs.

Selection

To review volunteer applications, you may want to organize a screening committee, composed of all the people who helped with the actual interviewing. The committee provides for several points of view and also helps to eliminate personal prejudices that might color the selection process. In addition, it can be honestly stated to those volunteers who are not selected that no one person was responsible for eliminating them.

When the coordinator does feel it is necessary to reject a volunteer, it is important that this be done through a personal meeting or phone call. It is helpful to the volunteer for the coordinator to share why she or he was not accepted. One also can inform the volunteer of other volunteer programs in the community in which she or he might be interested.

The time spent interviewing and screening applicants is a good investment in the agency's future and the accomplishment of its goals. Good volunteers can make a program work. Poor volunteers create problems instead of solving them and drain staff energy instead of supplementing it. Before you make a heavy investment in training your volunteer staff, be as sure as possible that each has the basic maturity, intelligence, and commitment necessary to make a meaningful contribution to your agency. ▭

Using Volunteers in Your Agency: Training Package

Using Volunteers in Your Agency: Planning, Implementing, and Maintaining a Volunteer Program is a training package designed to increase the number of volunteer programs in alcohol service delivery agencies and to upgrade those that already exist. The 8-hour training program is for the alcohol service professional who is or will be the agency volunteer coordinator. The course explores the pros and cons of volunteer use in alcohol service agencies; principles of effective program development; and a systematic process for planning, implementing, and maintaining a program. It also provides an opportunity for participant analysis of agency readiness to begin program planning and identification of initial program development tasks.

The training package relies on group discussion and problem solving, sound filmstrip presentations, individual paper-and-pencil task assignments, and requires a trainer with experience in planning and management of volunteer programs and expertise in group dynamics, management of training events, and use of audiovisual equipment. The package includes the Volunteer Program Development Guide, participant take-home book and primary trainer resource; a Trainer Manual which includes masters for handouts, overhead transparencies, and evaluation instruments; trainer Session Outline Cards; and two sound filmstrips (filmstrip and audio cassette). It is designed in four sessions ranging from two to two-and-a-half hours duration, and can be modified or adapted to meet local training needs.

Produced by the National Center for Alcohol Education, for the National Institute on Alcohol Abuse and Alcoholism, this training package is available free of charge to qualified agency representatives. To order the material, write to NCAE, 5530 Wisconsin Avenue, Suite 1600, Chevy Chase, MD 20815.

"If there has been a movement of volunteers away from service into the self-help and advocacy areas, it must be largely because the volunteers feel they will be able to express themselves and have some real authority in these (new) groups, which the traditional service areas have not permitted.

—Sydney Harris, syndicated columnist for the *Chicago Sun-Times*

"A 1976 survey showed that 77 percent of the people in the volunteer field agree that school, college, or employment credit should be given for volunteer experience."

—Report from the National Forum on Voluntarism, 1980

The Veterans Administration Voluntary Service Program

Larry was uncomfortable as he sat in front of the imposing desk, and he couldn't conceal it throughout his job interview; his eyes scanned the floor as if answers to the questions were woven into the carpet. He never made eye contact with the interviewer and spent more time telling how much he couldn't do than how much he could do. After a few more questions and a few more apologies, the interview was over. The man from Southwestern Bell Telephone Company came around from behind the desk and sat next to Larry.

"Not bad for a first crack at this, Larry," he said. "Let's go over the strong points and the weak points of the interview and see how to improve it."

Larry and the man who interviewed him are part of a unique volunteer program arranged between the Veterans Administration and the Topeka Chamber of Commerce. Business people from the chamber volunteer to conduct mock job interviews with veterans who are being discharged from the vocational rehabilitation program.

The chamber volunteer works with the veterans in building both the interviewee skills and the confidence that can help land an appropriate job. The Tulsa program is one of hundreds of volunteer programs at VA hospitals and outpatient clinics across the United States.

The Veterans Administration is the Nation's single largest health care system with 172 medical facilities throughout the country. And the VA has what may be the largest volunteer network of any organization in the Nation. Since the VA's Voluntary Service program was formally established in 1946, more than 225 million hours of service have been contributed by volunteers. This year, volunteers will have contributed more than 10 million hours of service and over $7 million in donations of funds and supplies. About two-thirds of the 78,000 current VA volunteers are members of veterans', service, or community organizations; the other one-third are not affiliated with any organization. The volunteers are recruited in a variety of ways. Many veterans' organizations have a tradition of volunteer service to VA hospitals and regularly offer their services, but to supplement the services of veterans' organizations, most VA hospitals conduct an active volunteer recruiting program.

Robert Marling, chief of Voluntary Service at the VA Hospital in Topeka, described a recruitment approach that uses volunteers to recruit other volunteers. "We have a 9-minute slide-tape presentation about volunteer service opportunities at the VA," Marling said. "Volunteers from veterans' and service organizations present this before a variety of community groups. Sometimes we get an entire organization to pledge its support and sometimes the group members volunteer on an individual basis." In addition to bringing in volunteers, the volunteers at the Topeka VA Hospital bring in business. Through the efforts of volunteers, many businesses in the Topeka area have contracted with the VA to produce a variety of products. Patients in the vocational rehabilitation program not only earn money but often develop valuable work experience that can be used once they are discharged.

Most VA hospitals have similar procedures for volunteer orientation and training. New volunteers are interviewed by a staff person from the Office of Voluntary Service to determine what area they would like to work in as well as their qualifications and skills for working in that area. Volunteers are then assigned to a staff person who manages their time and performance.

Like any organization using volunteers, the VA faces a challenge in keeping volunteers motivated. One way it approaches this is to make sure the volunteers get an assignment that he or she is happy with. Staff supervisors closely monitor the performance of the volunteers and arrange for a new assignment if the volunteer is unhappy with the first one. Moreover, the volunteers are recognized through award ceremonies, certificates of appreciation, and the sincere gratitude of the staff and patients with whom they work. For further information, contact Edward F. Rose, Director of Voluntary Service, VA, 810 Vermont Ave., Washington, DC 20420. □

—John McGrath, Staff Writer

Women Volunteers: Then and N.O.W.

From the days of colonial America, women have played a dominant role in the volunteer forces addressing a range of social and health problems. Alcohol problems were a dominant focus of the early volunteer efforts of women in this country. In the 1700s, many women felt that "intemperate" drinking would destroy the fabric of civilized society. In the 19th century, the average American woman felt that liquor "ruined the men and children for whom she had moral responsibility" (Sandmaier 1980). Because they had suffered "misery and helplessness in the face of men's drunkenness," women became active volunteers for the temperance cause. Eventually, the temperance movement would "unleash" American women "with such power that historians acknowledge that, were it not for women, Prohibition could never have been enacted," according to Manser and Cass.

Voluntary work undertaken by women in the 19th and early 20th centuries—including temperance agitation—allowed them to participate in some activities that had previously been dominated by men. Temperance work helped American women break out of their stereotyped image as "helpers" and assume a more influential role in American society. While a great deal of public attention was focused on the ax-swinging Carrie Nation stereotype, women in the mid to late 1800s began to form highly organized groups that focused on affecting public policy regarding alcohol use.

The founding of the Women's Christian Temperance Union (WCTU) in 1874 was key in the movement toward social equality for women in this country. WCTU members realized that their lobbying efforts on behalf of prohibition were not being heeded by politicians, who cared little for the concerns of nonvoting citizens. WCTU president Frances Willard (1879-1898) commented that "women need the vote to win prohibition." Therefore, soon after it was founded, the WCTU began to support the suffragist movement. At Willard's urging, a Department of Suffrage was created in the WCTU, and its volunteer staff produced more than five million pages of literature per year. The WCTU still continued to work actively for alcohol reform during this period, however; in fact, its suffragist link brought it many new volunteers. According to Sandmaier, "For their part, many of the foremost proponents of women's sufrrage, including Susan B. Anthony, Elizabeth Cady Stanton, and Lucy Stone, sincerely supported the temperance cause, having honed both their organizing skills and their feminist principles on the antiliquor movement." As America entered the 20th century, it was virtually impossible to tell the temperance advocates from the suffragists, so closely linked were their efforts. And it was impossible to deny the success of their voluntary efforts: in 1919 Prohibition was enacted, and in 1920 women were given the right to vote.

In the years following the Prohibition victory, women assumed increasingly influential roles in the voluntary sector, including the battle to overturn the 18th amendment. The Women's Organization for National Prohibition Reform (WONPR) emphasized that its involvement in the reform movement was linked to the concerns its members had about Prohibition's effect on the family. Bootlegging was flourishing as a result of Prohibition. According to WONPR founder Pauline Sabine, "Mothers had believed that prohibition would eliminate the temptation of drinking from their children's lives, but found instead that 'children are growing up with a total lack of respect for the Constitution and the law.' In the future, could governments pass laws and expect that citizens would observe them?" she asked (Kyvis 1976). The WONPR played a major role in bringing about repeal of the 18th amendment.

Women continued to be a dominant force in voluntarism, as the public perception of alcohol problems evolved from a moral to a public health perspective. Women historically have constituted the majority of volunteer forces in the United States; the growing number of programs and organizations seeking to prevent and treat alcohol problems in the 20th century have certainly benefited from the support of female volunteers, although statistics on the proportion of female to male volunteers in this

particular area have never been collected. Overall, however, women are in the majority of those who volunteer their time, and women volunteers contribute more time on the average than do men, according to a 1981 Gallup Poll.

Ironically, the burgeoning women's movement—which has its roots in women's involvement in voluntary efforts to address alcohol-related problems—has led some women to question many of their traditional roles in society, including their commitment to voluntarism. Had voluntarism held them back at the same time that it was liberating them? Women who sought to transfer the knowledge gained volunteering to paying jobs or academic pursuits often found that, in the "real world," volunteer experience was considered "no experience." Recently, the National Organization for Women (N.O.W.), in acknowledging that the public's view of voluntarism is sometimes less than positive, urged women not to volunteer until such work is accorded its full value. Former N.O.W. board member Tish Sommers said, "Women volunteers traditionally have been taken for granted, although attitudes have changed in recent years. At the same time, because inflation and expanding opportunities are bringing many more women into the work force, the numbers of female volunteers have decreased."

Many women were influenced by the N.O.W. doctrine, stating that volunteering is exploitive and degrading and takes away a paid job that would be provided by society if it were sufficiently valued, and that there should be equal pay for equal work. Many believe that these views resulted in a significant reduction in volunteering among women between the ages of 25 to 45, the so-called "typical" volunteer. Others have observed that many women who continue to volunteer feel guilty about doing so, or angry because they are being "used."

On the other hand, says the report, the women's movement has had a positive impact on volunteering. It has certainly increased awareness of the valuable role of women and has opened up additional positions to women within the volunteer ranks.

According to a 1980 Gallup Poll on voluntarism in the United States, there is little difference between the percentage of women and men who have reduced their commitment to voluntary activities in the past 3 years. Twenty-nine percent of men and 31 percent of women said they spent fewer hours on volunteer work in 1980 than in 1977. But 34 percent of men and 37 percent of women say they increased their volunteer commitment during the same time period.

The alcohol field has recently focused increased attention on women, particularly the so-called hidden woman alcoholic. There are now 43 State task forces on women and alcohol—up from 1 in 1974—focused on reducing alcohol problems among women, and also serving to bring more women into the volunteer force. For instance, "Women Reaching Women," a project of the volunteer resource development program (VRDP) of the Wisconsin Association on Alcohol and Other Drugs (WAAODA), is "a response to the needs of many women in Wisconsin who require drug and alcohol treatment and are not receiving such services," as well as an attempt to increase the number of women volunteering to work in drug and alcohol programs. The project is coordinated at the State level through WAAODA and is sponsored at the local level by alcohol and drug agencies. WAAODA provides training to the local agencies in volunteer management, as well as direct technical assistance in establishing volunteer projects.

According to project director Patsy Miller, officials at the VRDP-sponsored program so far have trained 15 volunteer coordinators—women who will return to their home communities and actively recruit other female volunteers to help women with alcohol or drug problems. Miller says that the coordinators receive full instruction in all aspects of alcohol-related voluntarism, including "how to recruit and work with volunteers, the *need for* volunteers, and statistics and other specific information on alcohol and drug abuse among women." While the actual form voluntarism takes differs from community to community—some groups devote their time to speaking about or distributing materials on substance abuse, while others care for the families of women in treatment—the spirit is the same: "The volunteers we train all are women, and the training they receive is geared toward women in need," Miller explained. "We truly are 'women reaching women.'" □

—Jill Vejnoska, Staff Writer

A 1979 study for the Coalition of National Voluntary Organizations determined that the average individual's yearly contribution to charity was $358.

Volunteers Support Legislation For Health Insurance Coverage

Michigan volunteer groups have found that joining voices in a single chorus is often the best way to gain a hearing from State legislators.

Eleven statewide associations and agencies concerned with alcohol and drug problems recently combined forces and deployed their volunteers in a statewide information campaign to advocate passage of legislation requiring provision of insurance coverage for alcoholism and drug treatment. Their efforts were phenomenally successful; they overcame the resistance of special interest groups in the State, which had blocked the measure for 7 years, and helped push through a bill that becomes effective in January 1982, according to Terry Hagan, Ed.D., Executive Director of the National Council on Alcoholism Michigan Division.

The group responsible, the Michigan Coalition on Substance Abuse, was created about 2 years ago. A Michigan legislator, Dave Hollister, had suggested that the fragmented approach individual alcohol and drug groups were taking on various substance abuse issues was doing them serious harm, Hagan said. With a more unified approach, however, there was hope of developing some real clout.

Concerned representatives met for the first time in hopes of agreeing on at least one issue. Represented were the NCA, Michigan; Michigan Alcohol and Addiction Association; ALMACA, Michigan; Michigan Association of Alcohol and Drug Abuse Counselors; Michigan Association of Residential Facilities for Substance Abusers; Michigan Association of Crisis Services; Substance Abuse Prevention Education Association; Michigan Association of Program Directors for Substance Abuse; Michigan Council on Alcohol Problems; Michigan Certification Board of Addiction Specialists; and the Michigan Association of Substance Abuse Coordinators. Most of these associations have volunteer boards of directors and primary voluntary staff members. Among resolutions passed at that first meeting was one that supported mandatory alcoholism and drug abuse treatment coverage by health insurers, favored by the group members because it ensured availability of services when budgets were tight.

The coalition members decided to invite volunteer members of their organizations to information sessions where they would be presented with facts about the legislation. The volunteers who attended agreed to pass on any information they received to elected officials and also to each convey the information to 10 other volunteers in their communities who would do the same. More than 200 volunteers were involved in this effort.

Printed information was distributed and participants were invited to argue about possible inaccuracies in information and to iron out differences of opinion so they could carry convincing and similar messages back to their communities. Insurance company representatives also were invited to meetings to discuss their point of view.

To emphasize the need for alcohol and drug treatment coverage, information was provided on the population affected; the cost to the consumer for alcohol related illnesses, lost productivity, and accidents; and the side-effects on families, home, and children.

To show that such insurance was affordable (insurers had argued that many who didn't need the services would face an excessive burden), the experience of other States was emphasized.

The volunteers were also shown facts indicating that treatment works. The alcoholic or addict becomes a productive worker and pays taxes that would not otherwise be paid, Hagan noted. For employers there is less absenteeism, and for unions it becomes easier to negotiate new contracts, he said.

When the volunteers returned to their communities they took on a new assertiveness as a result of being well-grounded in the facts. The effect on the legislature was "incredible," Hagan said.

Volunteers contributed to advocacy efforts at critical junctures in the legislative process, by

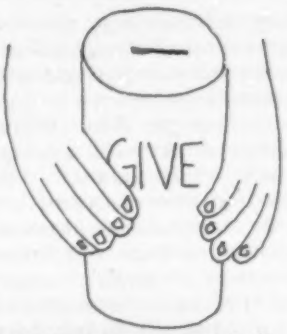
responding to requests for volunteer action. Fifteen such special requests were mailed out. Sometimes calls and letters to a specific legislator were needed; the legislators were inundated, Hagan said. During testimony before the joint committees on substance abuse, volunteers were requested to attend the meeting; more than 100 attended, he said.

The bill was passed, and there is a lesson to be learned, according to Hagan. "It didn't seem possible to overcome the special interest organizations but we did," he said. "Volunteers can influence public policy, not easily or without difficulty, but these things can be done. The hard thing is deciding what you want public policy to be."

There is no new insurance legislation immediately pending in Michigan. Work is beginning, however, on development of rules to ensure quality of treatment services. There is also talk of a public information campaign to focus on drunkenness and to convince people it is not "OK" to get drunk, Hagan said.

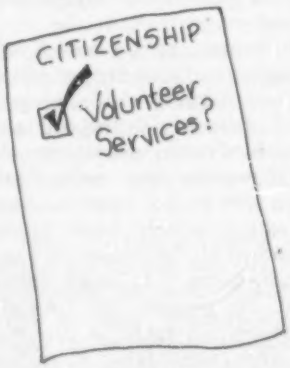
Keeping in mind that the more voices there are, the better are the chances of being heard, coalition members also are seeking new ways to join forces with other groups. Possibilities include cooperative efforts with those whose social concerns overlap the alcohol and drug area, such as human service agencies that deal with child abuse or senior services, he says. For further information, contact Terry Hagan, Ed.D., Executive Director, National Council on Alcoholism—Michigan, Inc., 2875 Northwind Drive, Suite 225, East Lansing, MI 48823.

—Nancy Johnson, Staff Writer



"Ninety-one percent of all volunteers have made a charitable contribution, compared with 66 percent among nonvolunteers. The group most likely to give a charitable contribution in a particular area is those who have volunteered in that area."

—Americans Volunteer 1981



"Americans must understand that volunteering is the rent that is paid for occupying the privileged position of free man or woman in this democratic society. Volunteering has to become a personal and public debt. . .an expectation of citizenship."

—Martin Koehneke, lecturer, author, and senior vice president of fraternal operations for Aid Association for Lutherans

"Upper socioeconomic groups are most likely to volunteer. More specificially, 63 percent of people with annual household incomes of $20,000 or greater and 63 percent of the people with some college education have volunteered in the past year. Additional demographic groups that are slightly more likely to volunteer include women, people under the age of 55, people who are employed, people with children still at home, surburban and rural residents, and people in larger households."

—Americans Volunteer 1981

A remarkable 27 percent of Americans—more than 40 million people—say they have engaged in such voluntary activities as helping the poor, sick, or elderly. Young people—those 18 to 29 years old—are less likely to be involved in this kind of work than are their elders.

—Gallup Poll, 1979

Volunteers Raise Clergy Awareness

A four-member volunteer squad is spreading the word about alcoholism to clergy throughout the State of Washington. At the request of local ministerial associations and similar groups, the volunteers take to the air, often on short notice, to present 1-day educational workshops on alcoholism anywhere in the State.

"Call and ask and we go," says Michael Schmidt, the volunteer who started the team, and who is also a counselor at Catholic Community Services and a teacher at Seattle University. Schmidt recalls how one volunteer arrived to pick up a ticket left for him the last minute at the airport, and when asked the destination, countered, "Isn't it on the ticket?"

Business has been brisk. In the past 3 to 4 years, the clergy committee of the Washington State Council on Alcoholism have spoken to 600 to 700 clergy of all denominations, both conservative and liberal, as well as to a group of nuns. Because each member of the clergy reaches a congregation of about 200 persons, the group feels it has made a significant impact.

According to Rick Weber, executive director of the State Council on Alcoholism, the clergy had been targeted long ago as an especially important population to reach with alcohol information. A research report issued by the Federal government revealed that 42 percent of all personal problems are brought to the clergy first. "They are like family doctors; the family trusts and listens to the clergyperson," Weber says. Yet a lack of training regarding alcoholism allows the clergy to "buy into the myths," so commonplace in the general population, that alcoholism shows moral weakness and a lack of character and that treatment is generally unsuccessful, he says.

In the past, efforts to educate the clergy had failed to get off the ground. Schmidt, a counselor who had worked in the past with a group of nuns, was nominated to rejuvenate the committee. Asked why he has been successful where others have failed, Schmidt said, "It's been so easy, it's surprising." Schmidt called about 20 people he thought would be interested in the project and eventually identified three enthusiastic Seattle volunteers: Father James E. Royce, director of the alcohol studies program at Seattle University and a member of the NCA board of directors; James Smith, M.D., director of Shadel Hospital, a local treatment facility; and Father Jack Marsh, a counselor at Catholic Community Services where Schmidt works.

A committee decided to develop a 1-day educational workshop that would increase understanding of alcoholism while building on the basic strengths the clergy already possessed. "Most clergymen are excellent counselors, yet they know little about alcoholism," he said. One survey had shown that 85 percent thought they had received inadequate training in the seminary, 75 percent had no active relationship with a local alcoholism program, and very few had attended AA or Al-Anon meetings. About 75 percent said that continuing education has been inadequate, and one-half said they had no basic pamphlet materials on alcoholism to hand out.

Relationships between the clergy and those in the alcohol field have been strained Schmidt says, because of the lack of alcohol training for the clergy and the tendency of those in the alcohol field to feel that other health and social service professionals are not interested in or well prepared to help alcoholics. "Our business has had a tendency to insult others—psychiatrists, doctors, and clergy—for the job they do," he says. The key, he feels, is to approach these people as professionals, using other doctors, lawyers, and clergy to carry the message. "It's about time we stopped criticizing and instead say, 'You know how to do something well, it's time to learn how to do it better,' " he says.

Another key factor in the group's success, he feels, has been getting local ministerial associations or similar groups and treatment facilities to cosponsor the workshops. The ultimate goal is to foster enough grassroots support so that the community will continue to deal with alcohol problems long after the committee leaves.

"We're talking about creating a volunteer voice. If we put this on *for* them, the effect is limited, but if we do it *with* them, it expands," he said. The local associations

handle mailings and general coordination while the State volunteers act as speakers and provide audiovisual materials and literature.

The local angle is also emphasized when, at the beginning of the workshop, an area minister gives a brief presentation, sometimes with one or more local parishioners who are willing to share their experiences as recovering alcoholics.

At lunchtime, representatives of local treatment services present brief statements about who they are and what services they offer. These include treatment and recovery houses, community alcohol centers (information and referral centers), AA, Al-Anon, and Alateen. Schmidt feels it's important for the clergy to have faces and names to whom they can relate. "They need to know these are nonthreatening people," he says.

In the afternoon, intervention is the focus. The clergy's role is discussed and techniques for recognizing and dealing with alcoholism explored. It is stressed that, although alcoholism is best treated by professionals in the field, the minister has an important role to play in helping the family recognize the illness and decide what to do, as well as in giving support to the family.

The volunteers answer questions at the end of the day, usually providing more detailed information on intervention, and focusing on specific cases the clergy bring up. During the workshop the volunteers try to encourage the clergy to transfer their understanding of alcoholism back to their own communities. They can place literature in the pamphlet racks, announce AA and Al-Anon meetings to the congregation, and attend those meetings themselves "since it's one of the best places to meet parishioners," Schmidt says. A prototype sermon has even been devised so that the clergy can carry the message to the entire congregation.

The goal is to get the clergy to actively advertise their "approval" of talking about alcoholism, he says. Otherwise people talk around and about their problems without even mentioning the subject. "Typically, the woman tells the clergyman her husband beats her but doesn't mention drinking or the husband says the wife ignores the child and doesn't mention drinking," he said.

He recounts how one clergyman refused his invitation to a workshop, saying "We don't have that problem among our churchmembers." Yet, the man came to the workshop several weeks later, having discovered that while he was away on vacation, two recovering members of his church council had to take a third in for treatment. Because the minister acted as though alcohol problems were nonexistent, they had not felt at ease sharing their difficulties, Schmidt says.

News of the volunteer workshops has spread and the volunteers find no need to advertise their services. Requests come in from those having heard of the group through word of mouth or occasional notices in bulletins and newspapers. Although Schmidt says the workshops were supposed to be a one-shot effort, they were so successful that the group has been invited back to two communities. They've also added a family counselor to their team for a requested presentation on working with the family.

Other evidence of the effectiveness of their efforts is that treatment centers are reporting more referrals from the clergy. Also, Schmidt has heard from clergy "within a week of the workshop who report individuals in treatment as a result," he says.

The volunteers also are receiving more invitations to speak to local church groups, and in some areas, the local groups have made attempts to develop ongoing training programs for the clergy. Clergy have been increasingly active in the alcohol field, often joining the boards of directors of local treatment facilities or participating in local chapters of the State alcoholism council.

Schmidt confesses to enjoying the hectic schedule and says the work holds special rewards for him; in particular, a spiritual one. Both the alcohol and ministerial communities have been supportive of the demands volunteering makes on the men, he adds.

Efforts to use volunteers to expand educational efforts to other professional groups such as doctors, lawyers, and nurses are also underway at the State council, according to Weber. Nurses have been very responsive, he reports. The Northwest Nurses Society on Chemical Dependence, now 2 years old, is a volunteer group that provides continuing education for nurses. They sponsor training seminars, meetings, conferences, and in some hospitals, inservice training. The council has provided funds for conferences, speakers' training, technical assistance, and information about contacts in other States, Weber says.

For additional information on the clergy committee, contact Michael Schmidt, 12607 Southeast 42nd, Bellevue, Washington 98006, or Rick Weber, Executive Director, Washington State Council on Alcoholism, 360 Bellevue Square, Room 217, Bellevue, Washington 98004. □

—Nancy Johnson, Staff Writer

AA Volunteers Provide Support To Inpatients

Editor's Note: The AA volunteer component at the Cuyahoga County Hospitals has been discussed in two published articles: Using the resources of AA in treating alcoholics in a general hospital, Hospital and Community Psychiatry *30(7): 480-482, 1979, and Recruiting and retaining AA volunteers in a hospital alcoholism program,* Hospital and Community Psychiatry *32(2):130-132, 1980. The first article was written by Gregory Collins and Jean Barth; the second was authored by Gregory Collins, Jean Barth, and Gary Zrimec.*

While the use of volunteers in a treatment setting is not commonplace, it can be very successful, according to Jean Barth, director of volunteer services at the Cuyahoga County (OH) Hospitals. For 5 years, Barth helped coordinate a program at the Cleveland Metropolitan General Hospital in which more than 60 volunteers from 14 area Alcoholics Anonymous (AA) groups, staffed the hospital's "Friendship Room" and assisted inpatients in the hospital's alcohol rehabilitation center. Gregory Collins, M.D., was also an active supporter and assisted in the development of the program.

"The program was very successful," said Barth, "but it required a large amount of planning and structure. You must recruit very carefully for these situations. Plus, it is extremely important to involve the professional staff in the development of a volunteer program. And, finally, you must impress upon the volunteers that they are first and foremost a part of the health care team and, as such, they must abide by the rules of the hospital while they are on duty."

According to Barth, prior to 1972, no specialized services for alcohol rehabilitation were available within the hospital. Patients were not admitted for detoxification or rehabilitation, but were only admitted for serious medical complications from drinking. Also at that time, the hospital's emergency room was "ill-equipped to deal with alcoholic emergencies requiring hospitalization," Barth said.

This began to change in 1972 when an AA member who was hospitalized for tuberculosis asked to attend an AA meeting during hospitalization. Since the patient could not leave the hospital, a call went out to a local AA contact and soon a Friday night meeting was started in the hospital's auditorium. To this day, it is one of the most successful meetings in the Cleveland area, attracting hospital patients as well as members of the general community, Barth reports.

Once the line of communication had been opened with AA, Barth said, hospital staff and administrators began discussing the introduction of alcohol services. Soon a committee was formed, which included representatives of the hospital's department of psychiatry, department of medicine, medical outpatient clinic, emergency room, department of social services, and volunteer services, plus the county welfare department.

Eventually, it was decided that steps should be taken to assist the emergency room with alcoholism cases and in 1975 the "Friendship Room" was opened. Nestled in a corridor near the emergency room, it was designed to provide assistance for individuals who came to the hospital intoxicated or with alcohol-related problems. Initially, the room was staffed by a small group of AA members, but it soon became apparent that more people were needed. All Cleveland-area AA groups were contacted

and soon members from 14 groups had signed up to staff the room. Each group chose a certain evening and, according to Barth, it was not unusual for three to five AA members to be on duty during evening and weekend hours. They provided coffee, discussed AA, and offered conversation. In choosing the volunteers, Barth said, the AA groups favored members with at least one year of sobriety and a capacity for helping other alcoholics. Also, if interest waned or a group kept missing its turn, a new group was recruited to fill the vacancy.

Soon after the Friendship Room was established, a grant was obtained by the Department of Psychiatry to launch an alcoholism rehabilitation center at the hospital. The center would provide inpatient detoxification as well as inpatient rehabilitation programs of individual and group therapy, with a staff of trained professionals.

When the center came into existence, the Friendship Room evolved into an evening alcohol program. Volunteers began visiting inpatients in their rooms, talking to those who were interested in AA, and doing "twelfth step" counseling. They assisted patients in making contact with AA upon discharge from the center and escorted patients to the Friday evening meetings at the hospital. Other volunteers acted as AA sponsors."

Said Barth, "The volunteers became a part of the hospital. The nurses and other staff knew who they were. However, it was still very important to screen potential volunteers and also to make sure they were not overzealous in their efforts with patients who were not interested in AA at the time."

Barth said there were occasions when volunteers would question treatment practices. At that point, center director Gregory Collins would meet with the volunteers and discuss the different types of alcoholism treatment. "They usually became very supportive of the hospital and did us a lot of good in the community. They gave us a link to the community and the other treatment networks that were already in place," Barth said. "The volunteers were quick to recognize any inadequacy in care or gap in service to the alcoholic patients. They helped to formulate new policy and programs to deal with these problems. They acted as casefinders in the community and attempted to motivate drinking alcoholics to seek help in the hospital."

In 1980, the hospital moved toward a day care treatment program which was less expensive for patients and allowed them to return home in the evening. As a result, the volunteer program was cut back. According to a hospital spokesperson, "hospital volunteers are now used in a different capacity. Besides being escorts for the hospital patients who wish to attend the Friday evening meetings, we also use professionals, both retired and active, who volunteer in our ongoing aftercare program, to assist in specific group therapy sessions each week, as clinical secretaries and as contributing and editing staff for our newsletter. Volunteers are a very vital part of the Cleveland Metropolitan General/Highland View Hospital. We simply could not afford all the services that volunteers provide if we had to pay them a salary."

For further information, contact Jean Barth, Director of Volunteer Services, Cleveland Metropolitan General/Highland View Hospital, 3395 Scranton Rd., Cleveland, OH 44109 or Gregory Collins, M.D., Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, OH 44109.

—John Small, Staff Writer

"In field after field of volunteer endeavor, the refrain from volunteers and volunteer managers is the same: the major barrier to effective volunteer involvement lies in the inability or unwillingness of paid helping professionals to accept volunteers as legitimate partners in the helping process. Such resistance is so pervasive that it generally is unquestioned by the vast majority of volunteer leaders and administrators in the United States."

—Report on the National Forum on Voluntarism
***Volunteer*, April 1980**

"It is important to test public officials and candidates about their understanding of voluntarism. . .Those who don't understand the historic and other values of volunteering are not adequately equipped to serve in public office."

—Senator David Durenberger (MN)

In 1973, the University of Michigan Survey Research Center estimated that volunteers donated more than 6 billion hours of time annually.

Dr. Harold Wolozin has estimated the value of organized volunteer work to the gross national product at approximately $36 billion annually.

***—Voluntary Action Leadership*, 1980**

Continued from page 7

host of societal problems that existed, and no one group had emerged to fill the service gap. Alcohol was viewed as a root cause of many social and health problems, and the temperance movement, as the voluntary alcohol work conducted between 1820 and 1850 came to be known, mobilized a whole new segment of the population.

The American Temperance Society (ATS) dominated the alcohol field during these years. ATS organizers took care not to affiliate the organization with any one political or religious ideology. In addition, while the MSSI had promoted the idea of temperance only for the lower classes, ATS members voluntarily took a temperance pledge. The ATS' purely democratic approach won it many supporters and brought it many new volunteers.

While the ATS was not a religiously-based movement, its philosophy was based in earlier spiritual movements that regarded all people as basically benevolent. Volunteers involved in the temperance movement also adopted the methods of the evangelical religious movement, which demanded that its followers take responsibility for their own actions and aid others who could not be responsible for themselves. The tract system, a tactic developed by evangelical leaders, was also used by the ATS to disseminate their message cheaply and efficiently throughout the country through a highly organized network of volunteers. The ATS tract system demonstrated that, with the exception of a few paid personnel at the administrative level, nationwide movements could be conducted entirely by volunteers.

The ATS' highly effective organization served as a model for later voluntary alcoholism movements. The networks established by the ATS—especially the formation of State, county, and local temperance societies which recruited volunteers who in turn raised funds for the movement and disseminated temperance literature— also benefited later-day voluntary organizations, such as the National Council on Alcoholism.

Abstinence Becomes A Goal

Formation of the Washington Temperance Society (WTS) in 1840 by six former drinkers marked a shift in emphasis in the American drinking habits. Despite the word "temperance" in its name, the WTS advocated abstinence. Because its founders and many of its early members had improved their lives by abstaining totally, this was the organization's perceived "solution for society's ills." As a result, a whole new group of volunteers was drawn into the alcohol field, recovering alcoholics. These recovering alcoholics were encouraged to testify about the evils of drink—a precursor of the methods basic to Alcoholics Anonymous (AA), founded some 80 years later. As the Rev. John Marsh recognized, "Men are not to be reasoned out of drinking." The Washingtonians used an emotional and psychological appeal for abstinence. During a typical meeting of a WTS group, three or four men would rise to recount their "down and out" days.

The effect that the Washingtonians had was unparalleled among voluntary movements in America. Tyrrell recounts that by the end of 1841 the society claimed 200,000 followers. "By 1843," he continues, "they claimed with heady enthusiasm that their following numbered in millions. Leaving aside the undoubted exaggerations of the new teetotalers, the reality was that the Washingtonians had acquired a mass following without precedent in the history of temperance reform." The extensiveness of the Washingtonian's following can be attributed to the organization's egalitarian approach to temperance reform—persons from every social class were active volunteers and their recruiting efforts cut across racial and social lines. As these lines were erased, the standard pattern of volunteering that had heretofore existed in the United States was altered. The "typical" volunteer was no longer a religious figure or a wealthy individual. In fact, there was no such thing as a "typical" volunteer.

Prohibition

In the 15 years following the founding of the WTS, the principles of organized activism that was spawned by the temperance movement gave birth to a massive prohibition effort in the 1850s. Petitioning, pamphleteering, and speechmaking reached new heights of professionalism as more and more Americans first sought passage of a law prohibiting the licensing of establishments to sell alcohol, and later attempted to enact general prohibition.

The prohibition movement quickly moved into the political arena. Maine was the first State to enact Prohibition in 1851. Maine's prohibition activists "established Maine Law committees at the town and county levels in the northern States and tapped the evangelical churches for financial support to provide money for touring temperance agents and for lobbyists at State capitals. Most important, they avoided political partisanship," Tyrrell says. "They deliberately

refused to form separate Maine Law parties but sought instead to persuade candidates of the existing political parties to pledge themselves in favor of the Maine Law." The Maine prohibition victory was followed by victories in other Northeastern States, as well as in Minnesota, Indiana, and Nebraska. The anti-alcohol volunteers had recognized the value of organizing effectively and of establishing linkages with powerful religious and political groups; at the same time, however, they had not allowed themselves to be drawn into these groups.

Prohibition brought volunteers to the alcohol field in huge numbers, but it also brought strong opposition. Eventually, prohibition was repealed, victim to the same fate that befell the Gin Act in Britain.

Voluntary activity related to alcohol issues continued to center on prohibition during the next 60 years, with equally active contingents in favor of and opposed to prohibition. In the 1930s, the repeal of the Eighteenth Amendment repudiated government's role as controller of access to alcohol, and the primary responsibility for dealing with alcohol issues returned to citizen groups. This was in keeping with America's overall social and political climate. Volunteers undertook to address an ever-increasing range of health and social needs as America faced the ravages of the Depression. The mobilization of the American public during the Second World War brought an estimated 11 million volunteers into every type of volunteer service, including those types more recently reserved for the professional, according to Manser and Cass.

The social and economic upheaval was accompanied by a rise in public concern about alcoholism in the United States. The Government was too busy fighting a world war in Europe and a war on poverty in America to provide services to "a lot of down-and-out alcoholics" (AA 1957), and the public attitude that had led to prohibition repeal discouraged government involvement in this drinking issue.

The focus of voluntary efforts in the alcohol field—traditionally focused on alcoholism as a moral problem—underwent a drastic change with the founding of Alcoholics Anonymous (AA). AA espoused a disease concept of alcoholism, taking it out of the moral sphere. AA's link with voluntarism was forged on the same day that that organization was born. *In Not-God: A History of Alcoholics Anonymous* (Kurtz 1979), the story is told of Bill Wilson's encounter with a recovering alcoholic while he himself was still drinking: ". . .when Ebby came along and one alcoholic began to talk to another, that had clinched it. My thoughts began to race as I envisioned a chain reaction among alcoholics, one carrying this message and these principles to the next. More than I could ever want anything else, I now knew that I wanted to work with other alcoholics." A "chain reaction." Rarely has a better or more fitting term been used in reference to voluntarism. What Bill Wilson, his co-founder Bob Smith, and other early members of AA envisioned was an organization in which one alcoholic's recovery would spark the next.

A chain reaction needs some solid base from which to begin; in much the same way, AA needed the example of a solid body of recovering alcoholics in order to ignite its own chain reaction of recovery. Many of AA's tenets—such as 12th Step work, sponsorship, and the personal testimony aspect of group meetings—draw on this concept. AA forms a chain, whose individual members may be weak, but whose whole cannot be broken. AA's members are linked by the realization that they, like Bill W., "needed to work with other alcoholics to maintain his own sobriety."

"Total" voluntarism, in an economic sense, was not part of the original AA plan. In fact, its founding members met with the administrator of John D. Rockefeller, Jr.'s, charitable fund, hoping to gain some financial support. While this individual was, on the whole, impressed by AA's accomplishments, he did pose one disconcerting question: "Wouldn't professional members spoil the man-to-man approach that is now successful?" (AA 1957). His concern was echoed by Rockefeller who told old friends that he admired AA, but added "I am afraid that money will spoil this thing." Bill Wilson later wrote that Rockefeller had been "guided then and there to save the AA fellowship from itself and from unnecessary hazards of money, property, and professionalism. It was one of the turning points of AA's history. His great wealth could have ruined us." Today, AA is supported entirely "by voluntary contributions from the groups, by funds derived from publishing activities and by individual contributions from members."

If the picture of sacrificing, spiritually-guided AA members is a familiar one, it may be because that scenario has appeared in voluntarism's history before. This historical connection was made by the Rockefeller fund administrator; hearing about AA and its work, he exclaimed, "Why this is first century Christianity!" (AA 1957) AA members do not live in communities, but they establish a spiritual community by working

together to become sober. AA members become, simultaneously, volunteers and the volunteered-for.

AA's success rate was phenomenal—by 1957, for example, the organization claimed 200,000 members in 7,000 groups in 70 countries—but it was not the answer for all alcoholics. Some could not accept the anonymity concept; others were unable to perform 12th Step work or disagreed with the financial philosophy; still others rejected the religious connotation of the "higher power" concept.

Public Awareness

AA's focus was on the alcoholic and his or her treatment and recovery. The idea that alcoholism was a disease was gaining acceptance and an even broader perspective was beginning to emerge. The Yale School of Alcohol Studies first convened in 1943, and the fact that the subject of alcohol consumption was being studied in an academic setting, was symbolic of a growing acceptance that alcoholism was a health, not a moral, problem. The Yale School's primary focus became education—studying the subject of alcoholism and then passing on new information about it to the public.

An active support group was needed to advance the three-part Yale plan of research, treatment, and public education. That group was developing right in the Yale School's own backyard. In 1944, Jellinek and his associates established the Yale Plan for Alcohol Studies, Yale Plan Clinics for the Treatment of Alcoholism, and the National Committee for Education on Alcoholism (NCEA). This last component, which later became the National Council on Alcoholism (NCA), supported nearly every activity conducted at the Yale School.

"With NCA and AA in the forefront, the efforts of volunteers have in this century brought alcohol problems and alcoholism recognition as a major public health issue."

While the NCEA received partial funding from the Yale School until 1950—in its first year, a total of $13,000—it quickly established itself as a voluntary group. Its founder was a volunteer. Marty Mann had played a prominent role in developing the whole "Yale Plan"; in the process, she "demonstrated what one person could do to advance treatment for many" (Chafetz 1979). Today NCA is supported entirely by voluntary contributions, and is involved in a number of education, research, and community service activities through an extensive network of State and local affiliates. Even before it became financially autonomous, it had made great strides in spreading throughout the country an awareness that (1) alcoholism is a disease, that (2) the alcoholic can be helped and is worth helping, and that (3) this is a public health problem and therefore a public responsibility.

NCA officials used networks not unlike those established so successfully by volunteers in the temperance movement, whereby local voluntary groups, or councils, affiliated with the national organization. The Greater Boston Council on Alcoholism, organized in December 1944 and operating by July 1945, became the first voluntary citizens group to affiliate itself with the NCA. Today, NCA has 207 affiliated Councils in the United States and 47 abroad.

In addition, national councils on alcoholism, based on the American model, exist in England, Ireland, Scotland, Canada, Australia, and South Africa. The NCA continues to expand its voluntary network; for example, local groups are encouraged to establish linkages with other voluntary groups, such as AA, the Jaycees, the Junior League, and the YWCA, when it appears that their alcohol education or prevention projects could benefit from a cooperative effort.

The accomplishments of NCA's volunteer network are as varied as the communities they serve. Most conduct ongoing public awareness activities, to educate the public that alcoholism is a disease as well as to make people aware of treatment resources. Affiliates are also addressing special needs in their areas. Many councils have assumed an advocacy role, working for mandatory treatment. Other groups have compiled directories of local alcoholism services. In other areas, the focus has been on raising awareness of the needs of special population groups or supporting alcohol education programs in the schools.

NCA has also spawned several affiliated professional groups, some addressing a specific service need. The National Nurses Society on Alcoholism (NNSA)

was formed when several nurses became concerned about the paucity of health care professionals with expertise and training in the treatment of alcoholism. The NNSA has identified the area of children experiencing alcohol problems, either among themselves or in the family, as one in which the skills of health care professionals need to be improved. This group is working with NCA to develop more specific nursing education in this area as well as a prevention model to deal with alcohol-related problems among children. In addition to NNSA, the American Medical Society on Alcoholism (AMSA) and the Research Society on Alcoholism are organizational components of NCA. Their members feel a commitment to learning more about alcoholism so that they can perform their jobs better; in the process, they provide "the voluntary alcoholism movement with the views of a specific professional element within the field," according to NNSA.

With NCA and AA in the forefront, the efforts of volunteers have in this century brought alcohol problems and alcoholism recognition as a major public health problem. Volunteers began to push for government involvement in the alcohol field—not government domination, such as England's Gin Act and America's 18th amendment had represented, but rather a "creative partnership directed towards common objectives, including the development and optional use of resources necessary for the control and prevention of alcoholism and alcohol abuse; and the reduction of the incidence of alcoholism and alcohol-related problems to the lowest possible level." An ongoing effort to form a strong alliance between the voluntary and government sectors culminated in the establishment of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1970.

NIAAA Support

The Institute, recognizing that volunteers have played a major role in the field as well as in NIAAA's founding, "has recognized and encouraged the vital work of volunteers," according to Loran Archer, Acting Director. In 1978, seeking to "support and build upon" the resource of voluntarism, and hoping to increase specific knowledge about creating and running effective volunteer programs, NIAAA initiated the Volunteer Resource Development Program (VRDP). The VRDP funded demonstration projects designed to encourage statewide development of volunteer activity in the field of alcoholism, to document and assess the impact of such activities, to demonstrate improved techniques and principles to enhance the contributions of volunteers in services related to alcohol abuse and alcoholism, and to develop self-sufficient organizations. Individual VRDP grants were competitively awarded for a 3-year period in 27 States and the District of Columbia by the end of 1981.

Most of the VRDP projects have been operated by State-level organizations, of which the great majority are State Councils or Associations on Alcoholism. NIAAA's intent is that "VRDPs work both to serve the alcoholism needs of the communities statewide and to maximize community involvement in the planning and implementation of project goals and activities." Each project has, in its own way, developed a voluntary network throughout the region it serves.

VRDPs have identified and developed volunteer resources in individual communities and sometimes linked them with one another in order to further strengthen the statewide voluntary network. In Ohio, the VRDP has developed a statewide resource center to provide technical assistance in volunteer programming to individual communities. The Pennsylvania VRDP brought together representatives of 375 Women's Clubs throughout the State for an information/education symposium on issues related to alcohol abuse and alcoholism. Some projects have extended beyond the alcohol field: the California, Pennsylvania, and Massachusetts VRDPs have used volunteers in intensive efforts to ensure adequate alcohol information and services within all of their State Health Services Associations (HSA), while the goal of the Georgia VRDP is to establish a Volunteer Committee for alcohol concerns in each of Georgia's Mental Health/Mental Retardation Service areas.

Traditionally underserved and minority population groups are the focus of several projects. Wisconsin's and West Virginia's VRDPs, for example, are designed specifically to involve women, both in alcoholism treatment and in voluntary efforts. Their efforts include public education and advocacy, networking activities, provision of training workshops, development and dissemination of newsletters and other informational materials, creation of support groups for women, and public awareness campaigns on special issues such as the fetal alcohol syndrome (FAS). The West Virginia VRDP has established women's task forces in each of seven State regions, working with coordinators in Community Mental Health Centers. Two States, New Mexico and

Montana, have designed education and training programs for Native American volunteers. And in North Carolina, the VRDP Task Force on Alcohol and Drug Abuse Among Blacks ensures not only that services will be provided for this group, but also that there will be adequate black representation on policy making bodies.

The New York VRDP developed and published a 334-page manual entitled *Managing Voluntary Organizations*, which has been used as a resource by alcohol and other human service organizations that use volunteers. The Oregon VRDP has provided training and technical assistance to staffs of alcoholism treatment agencies working either to develop or to expand volunteer programs, and the Michigan VRDP has held regional workshops on appropriate use of volunteers. Many VRDPs have enlisted volunteers to serve as advocates for enactment of specific legislation or for expansion of alcoholism services within their States. Volunteers recruited by the Utah VRDP, for example, worked with the Utah State Task Force on Prevention to effect passage of legislation strengthening driving under the influence laws, and were also instrumental in obtaining a sizeable appropriation for alcohol education in the schools. The New Jersey, Pennsylvania, and Massachusetts VRDPs have taken leading advocacy roles for such measures as required third-party payments for alcoholism treatment.

While funding for the VRDP effort has concluded, many of the efforts and projects stimulated by the NIAAA program will have long term effects, primarily because the Federal program focused on strengthening existing volunteer networks. Volunteers continue to make significant contributions to prevention—through NCA affiliates, local alcoholism councils, and countless independent parents and citizens groups. Volunteers will likely play an increasingly important role in intervention and treatment efforts, as funding resources shift and in some cases decrease. In these times of inflation and increasing competition for funding resources, the alcohol field has an historical edge. The rich, ongoing heritage of voluntarism on which the alcohol field is built ensures that the field will continue to meet the challenges of the future as it has in the past.

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Church members are far more likely to say they are involved in some sort of charity or voluntary social service work than are nonchurch members; 30 percent of church members and 19 percent of nonchurch members report they are engaged in this kind of work.

—Gallup Poll, 1979

Learning to C.O.P.E. in Union, Missouri

John D. King

Union, Missouri—population 5183—is located some 50 miles southwest of St. Louis. The residents of this semirural community of farmers, merchants, and commuters are typically American: they like baseball, hot dogs, and mom's apple pie. Unfortunately, Union is typically American in another way, too. It has a real problem with alcoholism.

Union has decided to do something about the growing incidence of alcohol problems. Union has decided to C.O.P.E.

C.O.P.E. stands for Community Organization for Prevention and Education, a volunteer "self-help" information and referral program begun by a small band of concerned Union citizens. The program is an outgrowth of the Missouri Alcoholism Volunteer Network (MAVN), a statewide Volunteer Resource Development Program funded by the National Institute on Alcohol Abuse and Alcoholism. MAVN's primary objective is the promotion, development, and implementation of volunteer alcoholism services.

The MAVN/C.O.P.E. relationship began in the spring of 1981 at a community awareness night held at the Union High School gymnasium. Some 200 residents came to the event, at which MAVN Project Director John King spoke on how communities can help reduce and prevent substance abuse. During the awareness night program, the committee of 5 persons who

sponsored the event were joined by over 100 people who agreed to participate in further activities and efforts to reduce alcohol and drug abuse in their community. With the assistance of MAVN, a series of planning meetings involving school, church, civic, and community leaders was held. A steering committee was charged with the task of recommending a structure and purpose for the still unnamed group.

The name became a first priority. Committee members felt it had to reflect the broadest kind of purpose so as not to alienate or disinterest any segment of the community. The idea was to have a structure, name, and public image that would draw people in, not keep them out.

After much deliberation and scores of ideas, the name C.O.P.E. was adopted. Both as a title and as an acronym, the name reflects the concern and purpose of the group's work. . . .to help their fellow citizens "cope" with those problems and life situations that often lead to abusive and self-destructive behavior, like alcohol and drug abuse, and to accomplish that task via prevention and education strategies.

So, in the summer of 1981, C.O.P.E. was born. The steering committee became the core of a citizens council. Things were beginning to move.

Over the summer months, C.O.P.E. arranged training for a variety of its interested parties. Students from the local high school attended the Missouri Teenage Institute on Substance Abuse (a MAVN program) to learn how to work with peers experiencing alcohol and drug problems. Prevention and counseling workshops were conducted for the elementary, junior high, and senior high school faculties. Most important, training was provided to C.O.P.E. members.

This training was designed to equip them with the skills necessary to carry out the group's adopted tasks: community education and awareness; information and referral counseling services; workshops to help families in communication, parenting, and other issues; dispensing literature; and establishing a drug prevention curriculum in the schools and churches.

The first major community-wide C.O.P.E. project was a campaign during Alcoholism Awareness Month in October 1981. Every conceivable organization was involved: schools, churches, civic and service clubs, scouts, PTAs, the media, law enforcement, and health. It was C.O.P.E.'s first chance to make a significant impact on its community.

And make an impact they did. C.O.P.E. members spoke, wrote, announced, attended, briefed, referred, and counseled. October was truly a month of awareness for the residents of Union. "I never realized how much our community needed something like this until we began C.O.P.E.," shared one council member. "What we're doing is long overdue." C.O.P.E. is a prime example of how local citizens can effectively affect and aid their community in a positive way.

C.O.P.E.'s future looks bright. Local civic clubs have underwritten much of its financial needs and citizens are responding to C.O.P.E.'s programs. C.O.P.E.'s long-range plans call for a more permanent structure with year-round programs. There's even the hope of local tax support in the future. And all of these efforts and plans are the result of "volunteer" work.

Alcoholism will doubtless continue to exist in Union, though some folks in Union like to think it won't be the same kind of problem. Why is that? Union is learning how to "cope." □

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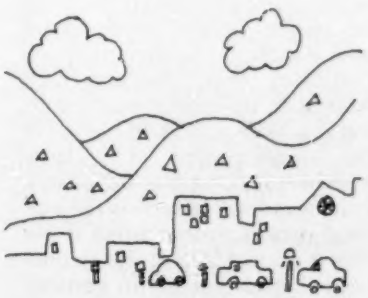

Many Americans appear willing to donate volunteer time, according to several Gallup Polls:

- *Urban residents would be willing to donate an average of 9 hours per month to voluntary service; projected to the whole population, "the hours available per month come to the staggering total of approximately one billion."*
- *"About one-half (52 percent) of America's urban residents say they would be willing to serve without pay on city advisory committees to study problems facing their cities and to make recommendations."*

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on the number and kinds of individuals who will remain active in the field. Recognizing that the American public is the best educated and most politically sophisticated in the world, the attractiveness of voluntarism is in direct proportion to the relevance of the assignment for the volunteer.

Today, the consumer as volunteer is of growing importance for the alcohol field. The consumer advocacy movement has grown in power and sophistication. It is now, and will continue to be, necessary to provide volunteers with meaningful tasks in the areas of public policy development and planning. The alienation and cynicism that characterized American political thought during the 1960s and 1970s has led to the development of a large number of consumer advocates, concerned with affecting the political processes that affect them. This is no less true of the alcohol field than of society in general. The alcohol program that seeks to attract consumer advocates as volunteers must ensure that the volunteer feels his or her presence and actions are having an impact on shaping policy and program activities.

Particularly noteworthy in recent years has been the rise in minority advocacy activities in the alcohol field. On the local, State, and Federal levels, minority groups have successfully advocated for services and for inclusion of ethnic and other special interest groups in decisionmaking and programming that affect their own communities.

Economic Considerations

Another strong influence on who can and will volunteer is the American economy. The current trend of the American labor force into service-oriented rather than product-oriented employment may well contribute to a rise in voluntary activities. Because the service industry employee does not usually see tangible, direct results of his or her labor, such individuals may seek personal fulfillment in outside activities.

Further, the American work week is becoming shorter, with increased leisure time available to the individual. While much of this time will be spent in recreational or other personal activities, there is reason to believe that some individuals will choose to spend some portion of their time in voluntary activity.

There is a school of thought that contends increases in inflation will result in a decline in voluntarism. This may apply in isolated cases. It appears likely, however, that if the rewards are great enough, individuals will find the time to participate. Since most voluntary activities require a commitment of time rather than finances from the individual, inflationary situations may make this activity even more attractive.

Quality of Life

Finally there is a new emphasis on the quality of life in the United States. The rise of environmental groups, the focus on healthy living, and the general repudiation of conspicuous consumption are indicators of a growing tendency to examine our American lifestyles. This is probably the single most positive trend for the future of voluntarism in the alcohol field.

If we view the whole range of alcohol-related issues, with the disease of alcoholism taking its place as one of these issues, then alcohol-related issues—more than any other social or health problems—directly affect the quality of life in every community in the Nation. The moderate use of alcohol is and will remain an integral part of most adult Americans' lifestyles. However, many negative influences on the American lifestyle can be linked to inappropriate uses of alcohol. So long as we recognize that alcohol use must be visualized as a continuum and represents a dichotomy in American society, we can continue to attract an informed and powerful volunteer constituency.

The healthy use of alcohol is woven into the cultural fiber of the country. The unhealthy use of alcohol has a deleterious effect upon the whole Nation. It must be the mission of the alcohol field to address both issues. Given the historical development of voluntarism in the alcohol field and current trends in American society, it seems certain that there will continue to be an expanding range of opportunities for the volunteer both as citizen advocate and as service giver.

"People who volunteer in the areas of arts and culture, religious activities, work-related activities, recreation activities, justice, and informally/alone spent more hours per person volunteering in these areas than people when they volunteered in the area of social/welfare, education, politics, or community action work."

—Americans Volunteer 1981

Motivating Volunteers Requires Finding a Balance

The question facing social programs in the 1980s is no longer "How can we use volunteers?" We must use them. In an era when inflation is causing programs and individuals to focus more heavily on moneymaking and increasing our productivity without increasing costs, there is great competition for volunteers. So the question becomes "How do we motivate people and corporations to volunteer in or to support our programs?"

At the base of motivating people or corporations to support our program efforts—financially or with their time and talents—is providing them with a "payoff." The ingredients necessary to recruit and retain the volunteer have changed in recent years. The female-dominated, noblesse oblige motivated volunteer movement of years gone by has changed. Pure altruism remains a factor in the "payoff" for volunteering for some, while helping other people provides motivation for others, such as recovering alcoholics who volunteer in alcohol programs. Whatever the initial motivation to become involved, volunteers who stay and become dependable cogs in the system have found continuing satisfaction in their activity because they are allowed to make a contribution of value to themselves within a comfort zone of demands that permits effective, successful accomplishment. The feeding and nourishment of a cadre of devoted and excelling volunteers is dependent on an ability of the program staff to provide a balanced demand—enough to challenge, but not so much as to overwhelm.

When the volunteer who has offered skilled services, like bookkeeping, is instead asked to sell tickets for the current fundraising event, failure and frustration are inevitable. When the sky, quiet, well-organized volunteer is asked to solicit door-to-door for corporate contributions because he or she was so successful in staffing the direct mail campaign conducted last year, disappointment is predictable. A sure way to lose a volunteer is to ask the busy and responsible businessperson or any volunteer to attend a series of meetings that have a low rate of accomplishment. Only by offering an environment that fully cultivates and uses its tried-and-true veteran volunteers while at the same time providing opportunities to safely challenge the fledgling volunteer who hasn't quite found an identity in service can we develop and maintain the volunteer force that tomorrow's economy will demand.

—Judy L. Vaughn
Alcoholism Council of
Colorado Volunteer

A Bill Of Rights For Volunteers

Every Volunteer Has:

- The Right To Be Treated As A Co-worker
  - —not just free help
  - —not as a prima donna
- The Right To A Suitable Assignment
  - —with consideration for personal preference, temperament, life experience, education and employment background
- The Right To Know As Much About The Organization As Possible
  - —its policies
  - —its people
  - —its programs
- The Right To Training For The Job
  - —thoughtfully planned and effectively presented
- The Right To Continuing Education On The Job
  - —as followup to initial training
  - —information about new developments
  - —training for greater responsibility
- The Right To Sound Guidance And Direction
  - —by someone who is experienced, well informed, patient, and thoughtful
  - —and who has the time to invest in giving guidance
- The Right To A Place To Work
  - —an orderly, designated place
  - —conducive to work
  - —and worthy of the job to be done
- The Right To Promotion And A Variety Of Experiences
  - —through advancement to assignments of more responsibility
  - —through transfer from one activity to another
  - —through special assignments
- The Right To Be Heard
  - —to have a part in planning
  - —to feel free to make suggestions
  - —to have respect shown for an honest opinion
- The Right To Recognition
  - —in the form of promotion and awards
  - —through day-by-day expressions of appreciation
  - —and by being treated as a bonafide co-worker

—Mrs. Richard L. Sloss, Director
Office of Volunteers,
Pacific Area
American Red Cross

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four who support the activities of a wide-ranging network of volunteers. In addition, the staff helps to develop and provides support and assistance to nearly 20 regional councils on alcoholism across the State.

The work of the ACC is accomplished through a network of task forces and committees that draw members from local alcoholism councils, alcoholism service providers, and those working in a variety of related areas. Task force groups currently are focusing on such topics as women, geriatrics, and domestic violence. There are also a number of standing committees, including an Alcohol Awareness Week planning committee and a summer school planning committee.

Each task force sets its own objectives, and the staff members support the volunteers in implementing their activities. For instance, the Geriatrics Task Force recently sponsored a workshop on Alcohol and the Elderly. The staff contacted speakers whom task force members had identified and made physical arrangements for the workshop. The 5-day summer school, held each year since 1977, drew over 200 people last summer to 16 classes. Staff supported the volunteer coordinator for each class by taking care of necessary paperwork, helping to publicize the event, and providing clerical assistance.

The volunteers are the key to the success of the council. They are involved both in planning and in implementing the council's activities. Overall ACC goals and operations are decided by a 10-member executive committee, a select group of particularly active members of the 40-person board of directors. While the board of directors meet quarterly, the executive committee meets monthly, for 2 hours or more, to deal with the nitty gritty policy decisions that must be made to keep any organization going. They review the objectives set out by the task forces and give their final approval. They really set the agenda for our efforts.

Although on paper it looks like a pretty tightly organized and efficient system, the realities of day-to-day life as the manager of a voluntary organization are far from predictable. It takes an enormous amount of coordination, because there are so many different people and priorities involved. It takes flexibility, because volunteers sometimes bite off more than they can chew, and because volunteers can be tremendously creative and come up with good ideas for new projects that are really worthwhile. And it takes a great deal of energy.

In the more than 5 years that I have been director of the ACC, I have had innumerable reasons to be grateful for the talents and enthusiasm of the people I work with—the volunteers who are the ACC. There are also challenges. I have felt discouraged by the problems that have to be solved and the sheer scope of the work that must be done to support the myriad volunteer projects underway, especially on those days when, by 11 a.m., a half-dozen phone calls have altered the priorities of a half-dozen projects.

Rewards

Volunteers "own" ACC. The several hundred persons who work directly within our network of committees and task forces look at ACC as their organization, and take responsibility for its objectives, especially the ones in which they participate. They care about its successes and failures, accomplishments, and hopes.

It is important that staff foster this sense of ownership in the programs and projects that volunteers carry out. Our task forces and committees have a better than 90 percent achievement rate in meeting the objectives they have set. In part, I think this is because we try to be sensitive to the fact that the overt leadership must come from the volunteers. The staff is very active, but we maintain a behind-the-scenes role. For instance, the staff may write a memo reminding task force members of the planning process for an upcoming event, but the volunteer task force chairperson signs it. And in consultation with the chairperson, the staff may draw up the agenda for the meeting, but the volunteer task force chairperson runs the meeting. It is their organization. We believe that, we support that, and it pays off.

Volunteers are proud of ACC. Volunteers appreciate other volunteers, and look at the accomplishment of current objectives as demands for more service, as well as an inroad into addressing some of the alcohol-related problems we are seeking to minimize. Success breeds success, as they say. Our volunteers don't rest on their laurels. When an objective is met, they usually say, "Where can we go from here?"

Because the volunteers feel the projects, and successes, are theirs, it stimulates enthusiasm and creativity. For instance, a domestic violence task force was formed, in response to concerns raised by local councils that there was a need for material on alcohol and domestic violence. ACC volunteers formed an ad hoc committee to develop materials, and they got so involved that they decided to try to set up some

workshops for professionals working with families. It may or may not get off the ground, but it's illustrative of the kind of excitement volunteers can generate.

Volunteers support staff. Teamwork and trust characterize the relationship among volunteers and ACC staff. The vast majority of our volunteers take their responsibility seriously and really run with the ball. There's just no way a staff of four could ever accomplish all that ACC does without the support and leadership of volunteers. I think a key part of developing and maintaining this mutually supportive relationship is that volunteers trust us, because they know we deliver the support they need, and they know that we genuinely feel that we are all essential parts of the same team.

Volunteers recruit volunteers. Just as success breeds success, volunteers attract other volunteers. And in so doing, they bring new life, vitality, and creativity to the organization. Perhaps because the needs are usually identified by the volunteers, there is an infectious enthusiasm that spreads to others in the community. The geriatrics task force is our best example of community networking. A core of ACC volunteers interested in the problems of the elderly and alcohol have been successful in involving other people not in the alcohol field, but with an interest in the elderly. This broadens our volunteer base, and it ensures that our information and awareness programs reach a much broader audience.

Each of the task forces and committees is chaired by a volunteer, and these people are very committed. Volunteers are most often attracted to a particular issue. People who are working in the alcohol field, as well as recovering alcoholics and Al Anon members, are very active as volunteers. More and more we are attracting people from other fields, such as with the geriatrics task force.

Our board of directors is also volunteer, and includes one person nominated by each local council on alcoholism as well as at-large members. This latter group is often identified through its involvement with a task force. And board members are very involved in identifying others in the State who they feel can make a contribution to the ACC. Again, it's most often a matter of volunteers recruiting volunteers.

Volunteers give visibility. A volunteer organization needs to be constantly spreading its wings if it is to achieve its objectives. The outreach that its members accomplish is usually the reason the organization grows and accomplishes its goals. Our objectives are spreading beyond alcohol-specific issues to involve people interested in other fields, and I see this as a very positive trend. We are beginning, for instance, to cosponsor workshops and other awareness activities with other organizations, reaching a much broader audience with information about alcohol problems and alcoholism.

Volunteers provide leadership. It is the volunteers, rather than the staff, who are out front. Volunteers chair the meetings, are the principle source of contacts, give credibility to the volunteer thrust of the organization, and act as citizen advocates. Leadership rises to the top and to the occasion.

Volunteers set directions. Volunteers are the source for creative ideas, new projects, interesting objectives, new directions, and identification of appropriate community responses to needs. They provide the blueprints as well as the engineers, carpenters, and interior decorators to make the blueprint come to life.

Volunteers raise dollars. In these times, fundraising is becoming a high priority and a time-consuming task. In this time of organizational responsibility to search for, and earn, the dollars it takes to support volunteer efforts, volunteers are accepting a challenge they may not previously have been called on to consider seriously. In our organization, we must rely heavily on volunteers to identify avenues for raising necessary funds and to support fundraising efforts with their time and ideas.

Challenges

There are many contributions that volunteers make, and many rewards for the staff of a volunteer program. The rewards are sometimes intangible, but most often they are very real. Just as real are the challenges facing the administrator of a volunteer organization. In an organization as diverse and vital as the ACC, it is a challenge to simply keep up with the needs generated by our volunteer activities. It is a job that stretches well beyond the standard 8-hour workday, and because of the many variables that come with a volunteer effort, it is unpredictable. Some of the potential problem areas I believe are critical to deal with, in my organization and others, are discussed below.

Fundraising is an increasing priority. A growing organization like ACC attracts people who suggest new activities, and that's great. Because of financial constraints and budget cuts, however, funding concerns occupy more of the staff's time than in previous years. It is increasingly

important, then, that staff of voluntary programs learn to competently support volunteer fundraising efforts without sacrificing the time they need to devote to the program objectives of the organization. Doing well the things that need to be done, and doing them on time, is not always easy.

Identifying appropriate volunteers is not always easy. While volunteers are quite effective in recruiting other volunteers, it continues to be a challenge to recruit volunteers who can help with management and the organization of projects. These very necessary, day-to-day coordination tasks are essential to the success of projects, and volunteers who can fill these slots are hard to find.

Volunteers don't always follow through. Although our volunteers have a very high level of enthusiasm and achievement, there are times when a volunteer's promise is better than his or her delivery. A tactful push and prodding, pleading, and poetry are often required to get the task accomplished. And sometimes we have to live with the fact that a planned project will simply not happen. I have found that it is important to respond as positively as possible to the volunteer who does not come through.

Priorities sometimes clash. While each task force sets objectives at the beginning of the year, and these are meshed by the board of directors into a cohesive plan of action, not everything is predictable in a voluntary organization. New ideas emerge, plans don't always come to fruition, and it's necessary to be flexible. When things don't work out as planned, or there are conflicts in how the organization's resources should be used, it becomes necessary for the director to assume the role of mediator. The time involved in this delicate balancing act is far exceeded by the time it takes to put an abandoned project together without volunteer help or to explain its demise.

Volunteers' suggestions should be taken seriously. It is important to listen to all the suggestions offered by volunteers. But following up on every suggestion often can't be done. The director who works with volunteers must learn to say no as often as yes, or to defer a response, or to channel the idea to another volunteer. Certainly the organization can and should grow. But if we grow too far and too fast, we will do things poorly. One of the difficulties we all have—staff as well as volunteers—is trying to do more than we can reasonably do. It is important to keep a clear focus on our goals, and to limit our objectives to a level that is accomplishable.

Volunteers burn out, too. Much is made these days of staff burnout, but volunteer burnout is just as real. We need to constantly be alert to the need to recruit new and creative volunteers, and to be sensitive to the needs volunteers may have to phase out or cut down their levels of involvement. In working with volunteers, the staff must be nonjudgmental and understanding of the fact that people's priorities and ability to give of their time and energy change. We can appreciate their contributions and empathize with their need to take a break.

The challenges are many, and not always easy to solve. Overall, however, the ledger shows a result that is much more positive than it is negative. All the volunteer hours, the people touched, attitudes changed, and awareness raised make it a worthwhile enterprise. On balance, Volunteers are a tremendous Resource and the Development of a Program to educate, inform, and sensitize is both cost-effective and productive. And I'm glad to be a part of all that. □

"Among adults who have volunteered in the past year, the largest group (44 percent) first became involved in the volunteer activity because they were asked by someone if they would volunteer. Other sources of information or reasons for becoming involved in the volunteer activity are having a family member or a friend involved in the activity (29 percent) and through participation in a group or organization (31 percent). One person in four (25 percent) sought out the activity on their own. Relatively few (6 percent) first volunteered because they had seen an ad for or some information about the volunteer activity in the media."

—Americans Volunteer 1981

Americans donated more than $40 billion to charities in 1978, more than $110 million per day.

—American Association of Fundraising Counsel

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ple a chance to talk about their problems and to discuss the options available. Close ties are maintained with different community organizations that occasionally are called upon for immediate intervention. For example, one itinerant alcoholic woman had to be picked up at a bus station, so we called an appropriate organization and kept in touch with the woman until a representative arrived. Followup telephone calls made by volunteers provide invaluable information on how well different community resources respond to people's needs.

There are no monetary rewards for volunteering. The reward of working on the helpline is the joy of touching lives, contributing to the community, and meeting interesting new people. The people we talk to often are so desperate that it is particularly rewarding to feel one can help. A lot of volunteers talk about that—the feeling they are helping. For those who are recovering alcoholics, it is also a feeling of paying others back for past troubles.

Recruiting Volunteers

As a volunteer I also have served as consultant to the Volunteer Resource Development Program (VRDP) in California, developing volunteer resources for alcoholism service providers in northern California health service areas. This broadens my horizons and gives me a chance to actively participate in community organization.

Volunteers bring a broad variety of skills to the alcohol field from all walks of life. In recruiting volunteers, I look for those who are both willing to learn and able to communicate and who have the time and interest to commit to a project. The elderly are a particularly good resource because they often have free time available; the energy of young volunteers is also a valuable asset.

I'm interested in those who wield a lot of clout within their communities or who have a particular interest in the alcohol field, because programs need volunteers who can serve effectively on citizen's committees and assess planning for alcoholism services. Such individuals generally have past experience working with governing bodies. Often it's best if the volunteers are not directly involved in the alcohol field. They have unique skills to offer and in turn find it particularly rewarding to learn about alcoholism. In general, I think it's become easier in recent years to approach people about volunteering in the alcohol field. People used to shy away from it because of the associated stigma.

Motivations

No two volunteers are alike. The incentives and rewards of volunteering depend upon each person's values, attitudes, degree of altruism, experiences, and self-development. Citizens who have accepted positions on the planning committees in northern California with which I work have a wide variety of reasons for becoming involved. A judge saw from his work how much planning was needed for alcohol services to be effective. A woman in the Junior League wanted to learn more about alcoholism because she had been appointed chairman of a committee on the subject within her league. A doctor who had started an alcohol clinic had a longtime interest in rehabilitation medicine.

It's a real challenge to find specific tasks to match a volunteer's interest, background, training, and capabilities. Whether I am participating in a project as a board member of an affiliate council, on the National Council board, or on a committee, I find the experience exciting whenever my time and energy are matched to specific tasks within my capabilities of involvement. To be in an appropriate job is an incentive to me—to any volunteer who feels rewarded by knowing that he or she is part of an important project.

For NCA volunteer projects like the helpline, our volunteer coordinator conducts detailed interviews with new volunteers to match them to appropriate and, it is hoped, rewarding tasks. A volunteer's skills may be more appropriate to a speakers bureau than to the helpline, for example.

One must guard against offering unchallenging tasks or excessively heavy responsibilities. I've seen some volunteers with excellent qualifications and high expectations become very discouraged. One woman, a physician's wife and a nurse, recounted to me how she had been put to work as assistant to an assistant at a local hospital, a low-skill position obviously inappropriate for her background. At a library, she was asked to shelve books. This woman desperately wanted to become involved and had some valuable skills to offer but was quickly becoming discouraged.

She is now attending training sessions in preparation for work on the helpline and is enthusiastic. Although slightly fearful of the responsibilities involved, the training sessions—which include discussion groups, role playing, observation of other volunteers, and listening to presentations about community resources—should gradually increase her confidence.

Sometimes the challenge gradually disappears from the volunteer's task or the person assumes

too many responsibilities, and signs of burnout appear. This becomes readily apparent early on if both volunteers and volunteer coordinator hold frequent get-togethers to discuss problems. To counteract burnout, attempts can be made to schedule more vacations or leaves of absence or to find the volunteer a more challenging position.

Although we continually hear that more sophisticated jobs are needed for volunteers, many routine tasks must still be completed. When there is a call for a special mailing, for example, or for many hands to be brought together for a specific task, the volunteers find time to offer their services at the most basic levels. Despite the tedious nature of these projects, volunteers are eager to participate, if they feel the importance of the job offers its own reward. At the helpline, paid staff pitch in as well; in fact, our paid staff and volunteers are virtually indistinguishable from one another. This contrasts markedly with practices in the past in which it wasn't uncommon to find volunteers occupying an inferior position in many agencies, and feeling dissatisfied as a result. Today, it is considered as important for the agency to be committed to the volunteer as it is for the volunteer to be committed to the agency. Contracts are drawn up, delineating volunteer responsibilities and solidifying a sense of mutual commitment.

Voluntarism is not new in American society, but it is an increasingly important part of it. Nearly 45 million Americans, or 1 out of every 5, is a volunteer. I'm proud to be one-- a "lamplighter" who has found the challenges and rewards of the past years to be an enlightening part of my own life. □

Looking to the Future

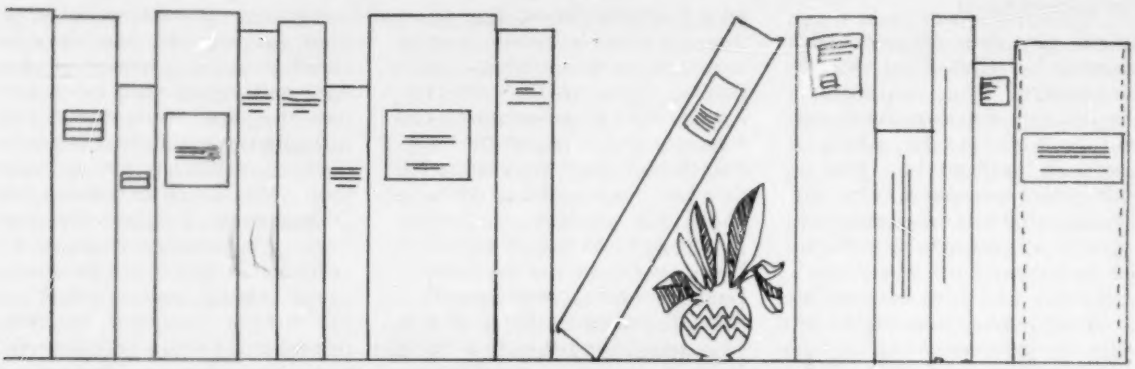
The most crucial problem facing voluntarism in the future may well hinge on economic realities. Service organizations may come to consider volunteers as primary care givers. Every human service executive, board, or advisory committee may have to consider many new ways to meet basic human needs. Which services to terminate or how to use volunteers more widely in order to deliver services may involve difficult choices. Qualified staff members can assume supervision and take on diagnostic and prescriptive functions while volunteers carry on the caregiving and special services to maximize the effectiveness of paid staff time. In no way do volunteers want to be substitutes for qualified full-time paid professionals. They are the first to speak out for appropriate professional competencies. Being brought in as a cheaper worker is not inspiring, but doing important work that is very much needed, is, indeed.

The ACTION census study (1974) cited impressive figures about volunteering, and if these trends continue, more than half of the United States population will be involved as volunteers. The challenge for the future is to devise ways to enable even more of the population to enjoy the benefits of having a volunteer and of being one, especially the elderly, the physically or mentally handicapped, children, and families. Volunteering is currently a means of broadening the scope of individual concern and understanding of all kinds of people. It may become a lifesaver if future economic and organizational needs so dictate. It would please volunteers to play such an important human services role.

—Harriet Naylor in
Volunteers, Resource for Human Services

An estimated four million young adults appear ready and willing to volunteer for a proposed national service program in which they would serve for 1 year either in military or nonmilitary work. Six million young people (18 to 24 years) indicated some interest in signing up for the program, while 77 percent said that young people should be given an opportunity to become involved in such a program.

—Gallup Poll, 1979



FURTHER READINGS

The following is a partial listing of publications on various aspects of volunteering and working with volunteers. A number of other publications and periodicals are produced by the organizations listed as information or technical resources. Most of these publications are not alcohol specific but deal with the human services field.

A "How To" Book for Volunteer Trainers (Revised 1976). Los Angeles Voluntary Action Center, 621 South Virgil Avenue, Los Angeles, CA 90005, $5.00.

By the People: A History of Americans as Volunteers (1978) by Ellis and Noyes. Energize, Book Orders, 5450 Wissahickon Ave., Philadelphia, PA 19144, $7.25 plus postage.

The Effective Coordination of Volunteers. National Center of Volunteers Against Violence, Domestic Violence Project, Inc., 32 N. Washington #6, Ypsilanti, MI 48197.

The Effective Management of Volunteer Programs (1976) by M. Wilson. Volunteer Management Associates, 279 South Cedar Brook Road, Boulder, CO 80302, $4.95 plus postage, 10 percent discount for 10 copies, 15 percent discount for 11 to 25 copies, and 20 percent discount for more than 25 copies.

The Exchange: For and About People Who Volunteer (1972 edition, about recognition). American Red Cross, Western Area Headquarters, Office of Volunteer Personnel, 1550 Sutter Street, San Francisco, CA 94119, single copy free.

Exploring Careers Through Volunteerism (1979) by C. Lobb. Richards Rosen Press, Inc., 29 East 21st Street, New York, NY 10010, $7.97 plus postage.

I-CAN, Council of National Organizations for Adult Education. Ramco Associates, 228 East 45th Street, New York, NY 10017, $10.00.

Interviewer's Guide (1975). City of New York, Board of Education—School Volunteer Program, 20 West 40th Street, New York, NY 10018, $1.00.

Leadership for Volunteering (1976) by H.H. Naylor. Dryden Associates, Box 363, Dryden, NY 13053, $4.50. (Include payment for single copy orders.)

Proof Positive: Developing Significant Volunteer Recordkeeping Systems (1980), by Ellis and Noyes. Energize Book Orders, 5450 Wissahickon Ave., Philadelphia, PA 19144, $7.25 plus postage.

Manual: A Process for Developing Agency-Based Volunteer Social Work Staff. Lutheran Social Service of Minnesota, Institute for Community Service, 2414 Park Avenue, Minneapolis, MN 55404, $1.00.

Recruiting, Training, and Motivating Volunteer Workers (1977) by A.R. Pell. Pilot Books, 347 Fifth Avenue, New York, NY 10016, $2.50.

Survival Skills For Managers (1980) by M. Wilson. Volunteer Management Associates, 279 S. Cedar Brook Rd., Boulder, CO 80302, $9.95 plus postage; discount for bulk orders.

Voluntarism at the Crossroads (1976) by G. Manser and R.H. Cass. Family Service Association of America, 44 East 23rd Street, New York, NY 10010, $10.00.

Volunteer Coordinator's Guide (1970). 7th Edition. University of Oregon, Department of Recreation and Park Management, Center of Leisure Studies, 138 Essinger St., University of Oregon, Eugene, OR 97403, $3.00 plus postage and handling.

Volunteer Training and Development (Revised Edition, 1976) by A.K.Stenzel and H.M. Feeney. Crossroad-Continuum, 575 Lexington Ave., New York, NY 10022, $12.95.

Volunteers in Rehabilitation (1973 series). Goodwill Industries of America, Inc., Central Services Division, 9200 Wisconsin Avenue, Bethesda, MD 20814, $11.00 complete set of 12.

Volunteers Today—Finding, Training, and Working with Them (1967) by H.H. Naylor. Dryden Associates, Box 363, Dryden, NY 13053, $4.50. (Include payment with single copy orders.)

What Volunteers Should Know For Successful Fund Raising (1981) by M.G. Gurin. Stein and Day, Briarcliff Manor, NY 10510, $10.00.

Women, Work, and Volunteering (1974) by H. Loeser. Civic Center and Clearinghouse, Inc., 14 Beacon Street, Boston, MA 02108, $8.95 or $4.45 paperback.

You and Your Volunteers: A Partnership That Works. State of New York Department of Social Services, Forms and Publications Unit, 1450 Western Avenue, Albany, NY 12203, no charge.

Your Volunteer Program (1970) by M.T. Swanson. Des Moines Area Community College, 2006 Ankeny Boulevard, Ankeny, IA 50021, $2.65 plus postage.

Compiled by Nancy Johnson, Staff Writer

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asked for and obtained the monies for Chit Chat. Esterly emphasizes that volunteers should not be overburdened, and each should be asked to approach no more than three or four major prospects. Also, he observes that often those individuals who appeared to be the busiest in maintaining heavy work schedules and who seemed to have the least time available for volunteering were in fact the fastest and most productive solicitors of funds.

The National Council on Alcoholism (NCA)—Alabama Division has recently used volunteers in a number of different fundraising efforts ranging from a special event golf tournament, in which contributors purchased holes and made other donations, to the selling of raffle tickets for an automobile. The Volunteer Resource Development Program Coordinator and Assistant Director of the NCA—Alabama Division, Alice Murphy, emphasizes that the program's survival and progress is clearly dependent on the board and other volunteers. She is optimistic about the future, since she has been greatly encouraged by past successes of the program's volunteer fundraising efforts. Murphy also believes that many of these special event fundraisers are important not only because they raise monies but also because they attract new people to the council and provide alcoholism education to both participants and the broader community.

The Cottage Program International, based in Salt Lake City, Utah, provides a variety of alcoholism prevention and family-oriented services. Volunteers have always been integral to the operation of this program. More recently, however, volunteers have been recruited to undertake a special fundraising effort that involves a public service announcement publicity campaign and a solicitation letter followed by a telephone call requesting monies. Within a 1-month period approximately 250 calls had been made, resulting in about 150 pledges of support ranging from $5 to $300 each. The Executive Director of the Cottage Program International Bernell N. Boswell, indicates that over a 5-year period the program is trying to build up a major constituency base of small contributors who will support the program on an ongoing basis. Boswell also has had considerable success in using volunteers to approach and obtain ongoing annual gifts of $100 to $5,000 from corporations and foundations.

The Executive Director of the National Council on Alcoholism (NCA)—Kansas City Area, James Eads, believes that volunteer involvement provides a good check and balance system to be sure that the program is effectively responding to major community needs. Also, active program participation by volunteers expands their knowledge of the services provided, increases their commitment to the program, and facilitates their success as fundraisers. Eads states that over 100 volunteers are involved in fundraising for NCA-Kansas City Area every year, and these volunteers regularly raise approximately two-thirds of the budget.

The Maryland Division of the American Council on Alcoholism (ACA) receives a considerable portion of its annual budget from United Way/Commerce and Industry Combined Health Appeal (CICHA). Through an alcoholism education and publicity campaign combined with the provision of a variety of community services and the use of active volunteers, the Maryland division has attained considerable visibility and a positive reputation. As a result many contributors to the annual CICHA campaign specifically designate their contributions for the division. The Volunteer Resource Development Program Director of the Maryland Division, ACA, William R. Miller, attributes many programmatic and fundraising successes to volunteers. He indicates that the volunteers not only contribute money themselves but also have a multiplier effect by encouraging others to give and designate their contributions for the Maryland Division, ACA. Also, such fundraising concurrently contributes to increased public awareness and education with regard to alcoholism program needs in the community.

Effective Strategies for Recruiting and Involving Volunteers

Volunteers should be encouraged to become involved in all aspects of program planning, implementation, and oversight. Different volunteers will be interested in different areas and can contribute in different ways. They must be given the opportunity to become meaningfully involved in the program. Such involvement will increase both their personal and their financial commitment to the program.

The highest level of program involvement for volunteers is on the board of directors of the organization. The traditional criteria for board member selection by the established human service agencies who recognize their fundraising needs have been the "three Ws": Wealth, Wisdom, and Work. For whatever reason, possibly because their funding support has in the past been provided primarily through

grants from Federal or other sources, alcoholism programs seem to have neglected the first criteria, wealth. Today, there is clearly a need for a change. Community leaders, including individuals who are wealthy or who have access to monies through personal, corporate, or foundation contacts, must be recruited to serve on alcoholism agency boards if these programs are to survive.

One logical place to begin in the recruitment of new board members is the board nominating committee. The selection criteria established by this committee should include the following: recognized leadership abilities; personal affluence and/or a wide circle of friends who are affluent or who have access to money through corporations, banks, or foundations; a commitment to the goals of the organization and a willingness to work; and prior experience in successful fundraising campaigns with other not-for-profit organizations.

Obviously, it will not be easy to recruit persons with all of these qualifications. Strong leaders are always in demand and particularly so today because of the fiscal situation in which many not-for-profit human service organizations find themselves. If alcoholism programs are to survive, however, they must compete for, recruit, orient, and involve leaders on their boards and fundraising committees.

There are a variety of resources available that will assist in the identification of strong community leaders. These include contacts of current board members; the local social register and social section of the major daily newspaper; corporate directories such as *Dun and Bradstreet, Moody's Handbook*, and *Standard and Poor's; Who's Who;* annual bank or corporate reports that include the names of boards of directors and executives; *The Foundation Directory*, which includes the names of foundation board members; and county clerk's office for information on major landowners.

Membership on the board of directors of a program is the highest level of involvement, and such involvement will often result in a critical difference in the level of giving or campaign support (for example, the difference between a $100 and a $1,000 or a $10,000 gift). Since all major actual or potential givers cannot be placed on the board, however, it is extremely important to involve such individuals on standing committees, ad hoc committees, and task forces, always being sure that the particular committee's work is of real interest to the prospective contributor.

Finally, with regard to volunteers and fundraising, it may be useful to remember that, if you truly believe in your case, it is much easier to educate and convince individuals with money to become committed to the program. Volunteers, including prospects, must be continually identified in alcoholism programs. Such involvement will prepare and encourage them to contribute monies to the needs that they encounter firsthand and to recruit other donors. Then these contributors must be asked to renew their giving at least annually, and to increase the level of their gifts whenever possible. Those volunteers who serve on a board of directors should meet the stringent requirements of the "three Gs"; they must Give, Get others to give, or Get off the board.

Even though a fairly extensive library of books, booklets, manuals, periodicals, and other materials is available in the fundraising field, most alcoholism programs are not yet familiar with these essential resources. In addition, there are two national organizations that provide valuable services in the fundraising area: the National Society of Fund Raising Executives is located in Washington, D.C., and the American Association of Fund-Raising Counsel is located in New York City. Both of these groups have established and enforced high standards for membership.

Those resources that deserve special mention because of their relevance to the alcoholism field or the high quality information they provide are included in the following list.

Balthaser, W. F. *How to Make Your Mark as a Solicitor of Gifts.* Ambler, PA: Fund Raising Institute, 1979.

Brakeley, G.A., Jr. *Tested Ways to Successful Fund Raising.* New York: AMACOM, Division of American Management Association, 1981.

Fund Raising Management. Garden City, NY: Hoke Communications, 1981.

Gurin, M.G. *What Volunteers Should Know for Successful Fund Raising.* New York: Stein and Day, 1981.

Kurzig, C.M. *Fundation Fundamentals: A Guide for Grantseekers.* New York: The Foundation Center, 1980.

Lewis, M.O. ed. *The Foundation Directory.* 8th ed. New York: The Foundation Center, 1980.

LRC-W Newsbriefs. Washington, DC: Lutheran Resources Commission—Washington.

NCA Fund Raising and Resource Development Newsletter. New York: National Council on Alcoholism, 1979.

National Institute on Drug Abuse. *Alternate Fund Development for Drug Programs: Resource Manual,* by Lopez, J.M.; Stone, M.J.; Coyington, L.E.; Sherard, M.L.; and Shapiro, P.D. Rockville, MD: NIDA, 1980.

Schneiter, P.H. *The Art of Asking: Handbook for Successful Fund Raising.* New Work: Walker and Company. 1978.

The Grantmanship Center News. Los Angeles: The Grantsmanship Center.

Warner, I.R. *The Art of Fund Raising.* New York: Harper and Row, 1975.

Wilson, J., and Kitzelman, V. *Handbook on Fund Raising.* New York: National Council on Alcoholism, 1976. □

TRAINING VOLUNTEERS FOR FUNDRAISING

Ralph Lidman

In Oregon, traditionally the county alcoholism councils have made alcohol education, prevention, and referral activities their top priorities. When the Oregon Legislature in August 1980 eliminated the State funds that partially funded these council services, local councils were facing severe cutbacks or the total elimination of these efforts.

So that the alcoholism councils can continue to provide these much-needed services, the Oregon State Council on Alcoholism (OSCA) developed plans for a statewide series of fundraising campaigns, to be carried out through the combined efforts of staff members and volunteers of local alcoholism councils. In a 1-day training session, a professional fundraiser has volunteered his services to teach these volunteers and professionals "How to Successfully Design and Conduct a Fundraising Event or Campaign." The training session will cover a number of topics, including recruiting volunteer fundraisers; effective solicitation (selling a cause and a "commodity," choosing and cultivating prospective donors, and approaching prospects peer-to-peer); types of fundraising projects (determining the type of project most appropriate to a specific locality and the expected financial returns for various projects); and selling your cause, or how best to answer a potential contributor's question of "Why should I give to you . . .?"

OSCA volunteer members and the volunteer professional fundraiser have already begun a fundraising campaign on OSCA's behalf, providing experience and materials that will be useful in training local alcoholism councils. The program brochure and pledge cards developed for use in OSCA's campaign, for instance, can be used as model materials for the 1-day training at the local alcoholism council level. In addition, volunteer members of OSCA who have used the materials to explain alcoholism and OSCA's work to members of their community in seeking contributions will share their experiences in the 1-day local level training session.

Ralph Lidman is Director of the Oregan State Council on Alcoholism.

In addition to developing fundraising skills, local participants will select during the 1-day training meeting a fundraising project for their council to undertake. OSCA will provide onsite technical assistance once the local council has organized the volunteers who are to conduct the project, including the services of the professional fundraiser as a consultant. The local councils will be expected to share the proceeds realized from the fundraising projects with OSCA, contributing 20 percent after expenses to the State group.

The series of planned fundraising projects throughout Oregon have two purposes. One is to raise money so that the services alcoholism councils provide in Oregon can continue. The second is to educate the community about alcoholism and the work alcoholism councils do to combat alcoholism. It also has been OSCA's experience that any public education activities attract new volunteers, so these fundraising efforts will not only expand financial resources to continue services that would otherwise be cut or eliminated but also increase the number of volunteers in the alcoholism field.

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ces, play a role in your service design, and spend time on your behalf should also garner several preferential dollar contributions because the corporations will be more aware of the good you do.

Working with corporate volunteers will not always be an easy task. In a agency already rocked by changes because of budget cuts, there may be adjustment problems as recommendations are made to cut pet projects, or as programs that have always operated well become the target of fine tuning to make them even more attractive. Priorities may change until the agency must question its own identity. Despite these difficulties, the corporate volunteer seems a promising answer to the problem of maintaining fundraising and volunteer efforts in a very competitive voluntary service area.

Will this plan for expansion of community resources dedicated toward the efforts of fundraising, education, and other social needs work? To keep a vibrant force of volunteers in this pressurized society will require the same creative activity that is required to find funding support. We have to look for the potential exchanges, the payoff for becoming involved. We have to search for the source of the volunteer pool of the future. Our services must be appealing to society, if we've any reason for being, and to our benefactors, if we're to keep them. We'll have to learn to pay as much attention to productivity in the volunteer field as businesspeople do in the marketplace. ☐

Reflections On Voluntarism

From "A Look at the Eighties," a report from the National Forum on Voluntarism:

"Inflation represents direct, immediate and visibly increased costs to the volunteer and to the organization. Increased costs without corresponding increases in revenue must at some point equal decreased service."

—Gordon Manser

☐

"In this period of severe stress for some and genuine concern about the future for many, voluntarism can be a stabilizing experience, a security harbor. This may be the greatest value accruing to the loyal millions who give of themselves despite the upheavals of the late '70s and the uncertainties of the '80s."

☐

"Despite the protestations of those who wish that the private sector might be made 'pure,' the fact is that the government does affect volunteers in non-governmental settings. Tax incentives, patterns of funding of new programs, and support through information and technical assistance services all play a role in defining the nature and effectiveness of the volunteer community."

☐

"Although volunteers are usually thought of as being a part of the voluntary sector, government has become one of the greatest consumers of volunteer energies. Although no precise statistics exist, it is clear that an increasing number of volunteers are being recruited to work in governmental programs at all levels—local, State, and Federal. Perhaps much more significantly, many million more are involved with agencies that receive a majority of their funding from public rather than private sources."

☐

"The experience of agencies using volunteers during the temporary 1974 gasoline shortage is instructive. The shortage reduced volunteer efforts so seriously that the chairmen of the boards of the National Center for Voluntary Action, the American National Red Cross, and the United Way of America jointly went to the Secretary of the Treasury to ask for special consideration for volunteers performing essential tasks. . . Finding alternatives to the transportation situation might involve travel reimbursement, carpooling, providing portal-to-portal transportation, or recruiting volunteers within walking distance. It may also involve bringing work to the volunteer or exploring the 'electric volunteer' (HAM, CB, interact radio)."

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find it highly useful in learning how to apply their theoretical knowledge to the practical setting.

It has been most gratifying to find that a lack of familiarity with alcoholism presents no problem in training volunteers for the Cottage Program. The focus of training is to teach volunteers to function as community educators. These volunteers initially are prepared to do door-to-door canvassing and similar tasks. As the philosophy and concepts of the program are internalized, some individuals become interested in additional training to become group meeting moderators or to fill other more demanding roles. The Cottage Program provides five levels of training, progressively preparing volunteers to work in more intensive roles.

Education the Goal

Essentially, the goal of the Cottage Program is to create an environment or background that promotes healthy behavior. It is based on the premise that drinking behavior is usually reinforced by the environment. Through simple reeducation, the people that make up the environment can be taught not to reinforce the drinking problem. Many times, those in the environment of a person with a drinking problem actually recognize the problem before the one who is drinking does so. In these cases, treatment must begin with them. It also has become increasingly apparent that a large part of the problem of alcoholism is the behavior of certain key persons living close to the one with the drinking problem. Thiis is especially true in family situations.

The Cottage Program helps those living with an alcoholic to learn to focus away from the drinking and toward being responsible for themselves, so that they are not looking on the behavior of another person as a solution to their own problem. Many times, those living with an alcoholic are suffering more from the alcoholism than is the drinking person.

In the majority of cases, family members and community members must learn to stop trying to change the alcoholic or to get him or her sober. They must cease reinforcing the drinking behavior. The entire family, environment, and community around persons with alcoholism can profit from education and can begin, even if only slightly, to initiate the recovery process.

Results of the Program

The combined data of 11 research studies have shown that prevention strategies have led directly to the following: a long-term increase in the community's understanding of the nature of alcohol misuse; a statistically significant agreement among our target population that alcoholism is a serious, yet treatable problem in terms of both economic and human costs; a general attitudinal shift throughout the community from the belief that alcoholism is indicative of a morally weak individual, deserving of social condemnation, to the belief that the alcoholic is suffering from a disease, and hence is deserving of compassion and humane treatment; enactment of new legislation passed recently in Utah that decriminalizes public intoxication; and an increase in public knowledge of the social services programs and organizations that offer help to individuals, families, social organizations, and private corporations who are experiencing alcohol-related problems.

These attitudinal changes have resulted in a lessening of the stigma associated with alcoholism. The decrease of this stigma increases the likelihood that people will seek and receive help for their problems associated with alcohol much earlier than they would have otherwise.

These results are important fallouts of prevention efforts for two reasons. First, the reduction of the stigma associated with alcohol abuse has an immediate and obvious impact and importance for successful treatment. Second, and equally important in human terms, is that reducing the stigma decreases the pain the alcoholic and the alcoholic's family suffer; they are hurt first by the physical and social pain of the disease itself and second by the overwhelming personal and psychological sense of guilt associated with a disease that is not culturally legitimate.

In some ways, it may be a philosophical mistake to try to engender social compassion for the alcoholic by legitimizing the source of his or her pain. A more direct, and I think, human, route is to ground caring and compassion in the realization that suffering itself is sufficient to warrant human caring. The experience of pain is a universal human phenomenon, whether or not there is an understanding of its particular causal antecedents.

Reducing the stigma of alcoholism does result in more humane treatment. But as concerned professionals, we should not make humane treatment even implicitly contingent on an idiosyncratic capacity to hurt from an infinite number of sources. The likelihood of running into someone in one's day-to-day professional life whose source of pain is not considered legitimate is high indeed. Hence, we cannot make shared understanding a personal

or professional precondition of caring.

This may seem to be a rather abstract, philosophical concern. However, it reflects the difficulties many prevention programs have in defining their goals and the means to achieve these goals. To a large extent, this dilemma is rooted in the ambiguous nature of prevention.

The Nature of Prevention

We can see some very important, although indirect results of the Cottage Program in Salt Lake City. However, after 9 years of hands-on community work, the compilation of 11 research studies, and a vigorous investigation of the literature, we do not know a great deal more about the psychological and social dynamics involved in problem drinking than we did when we began. Not only are we in want of specific information about the nature and etiology of problem drinking, but the psychology of human health—a logical precondition for any effective prevention program—is also not well understood.

Since the dynamics of human health, and even the specific factors that would allow us to predict who will and will not become an alcoholic, continue to evade discovery, should prevention efforts be abandoned until scientific understanding can catch up to the policies of social action? We think not. An analysis of the effects of prevention strategies yields some cause for optimism along with some grounds for needed caution.

Primary prevention can be defined as a proactive process that focuses on capacity-building for individuals, families, groups, institutions, and social systems, in order to promote the personal and social growth of the individual toward full human potential and thereby reducing or inhibiting physical, emotional, or social impairment that results from the abuse of chemical substances.

However, the definition lacks any reference to how the human growth and self-actualization are to be achieved. All too often, those professionals involved specifically in prevention betray the poverty of their discipline by their continual fixation on the last part of the definition of primary prevention, "reducing or inhibiting physical, emotional, or social impairment that results from the abuse of chemical substances."

The goal of many prevention programs has been "prevention of _____," where the blank is filled in with a specific disease of human malady. But two-thirds of the definition is concerned not with the "prevention of" but "promotion of _____," where the blank can be filled with a desirable human attribute or ability or the development of a general human capacity. If one were to take the definition seriously, the logic of health promotion would render the concept and practice of disease prevention obsolete.

During the November 1979 meeting of the North Conway Institute, an important point was raised: The field lacks information about normal drinking practices. For that matter, there is a complete lack of a psychology that explicitly elucidates healthy human behavior. The concept of normalcy is a psychological one, and it can not be derived from the mathematical concept of the average.

In order to develop a psychology of human growth, a minimal requirement would seem to be to at least begin with a study of a functioning population. But most definitions of mental health and mental illness that underly the practices of treatment and prevention have their origin in studies of acknowledged abnormal populations. The concepts of both "prevention of" and "promotion of" are grounded in clinical studies that have concentrated exclusively on the psychology of pain avoidance and symptom formation. The concepts of growth and individual actualization, if they are dealt with at all, are generally thought to be the end product of pain removal, or they are seen as a bonus in the rehabilitation of a damaged psyche. Traditionally, mental health has been regarded as the mere absence of mental illness.

The concept of personal growth and self-reliance has been a focal point of many personality theorists, including Jung, Adler, Sullivan, Rogers, Goldstein, and Maslow, for whom the supreme goal of man is to fulfill himself as a creative, unique individual according to his own innate potential and within the limits of reality. When he is deflected from his goal, he becomes, as Jung said, "a crippled animal." But such psychologies fail to explicitly define self-actualization and creativity, and they don't offer an analysis of the specific factors that are relevant and necessary for the promotion of human health.

Although research into mental health, as opposed to mental illness, is still in its infancy, there have been some significant studies. The existential philosophers made important contributions in the area of self-realization. Psychologists like Maslow, Fromm, and Laing point to the importance of an independent psychology of human potentiality, but their research does not go beyond an analysis of the experience of human achievement. Peak experiences and perfect moments are too lofty to be held

to earth by action-oriented prevention programs.

The revolutionary researchof Herzberg and Carkhuff (1976) has yielded some specific information about the positive factors involved in mental health. The factors necessary for providing a sense of personal growth are, simply put, the ones required for the real growth of an individual. They directly involve an individual in a task, project, or activity in which achievement is possible. The factors are achievement, recognition for achievement, involvement in a task for which one can be personally responsible, opportunity for growth by the development of abilities, and real psychological growth, which is the consequence of the preceding factors.

Application of Prevention Theory

It is these realities that are reflected in the Cottage Program. For both volunteer workers and meeting participants, the task involved provides an opportunity for achievement. It is a genuine task and an appropriate one, and it provides an opportunity for the individual to learn or achieve.

There are a number of prevention programs involved in skills training at the family level. They are grounded in a sound concept and a genuine insight into the importance of the family for primary prevention. However, in their hurry to impart skills, they must not lose sight of the fact that significant skills training needs to involve the development of real abilities that are connected with specific tasks.

A number of organizations teach communication techniques without emphasizing the importance of the fact that mastering the vehicle for improved communication is only significant if one has something worth communicating. An important insight of psychoanalysis was that techniques that do not support content can actually impair personal growth by masking very real inabilities and deficiencies.

A child learning to ride a bicycle might offer an illustration of what is meant. We can provide a loving, encouraging environment, instruct the child in bicycle riding techniques, and teach him the skills to express his desires and fears about riding the bicycle. But the fact is that the child cannot learn to ride a bicycle unless we give him a bike. Once he has the bicycle, we have to motivate him to learn. If he wants to learn to ride because he will avoid the unpleasantness of Dad's disappointment, the unpleasantness of peers' derision, the unpleasantness of his inability to participate in play activities, his motivation to learn is avoidance! Is he seeking happiness because by learning to ride a bicycle he avoids unpleasantness? The child who learns to ride a bike or play a musical instrument because he delights in the task and achieves satisfaction from accomplishment and mastery is so very different psychologically from the individual who complies out of the need to avoid the pain of nonacceptance.

We must be careful in our rush to achieve the goals of prevention to assure that our approach to training families and communities promotes healthy behavior rather than attempting to encourage people to avoid psychological pain and discomfort. We should not expect to develop mental health by employing techniques that are appropriate for the treatment of mental illness, or we rob individuals of the real accomplishments and satisfactions they might gain from genuine achievement.

Genuine human growth must risk failure. If all of our prevention strategies are directed toward protection, acceptance, artificial escalation of self-esteem, and unrealistic reduction of ambiguities, then we should not be surprised when our efforts do not result in actualizing human potential and individual growth. □

Based on an analysis of the most recent NDATUS survey, and on information from the 26 States participating in the NIAAA Volunteer Resources Development Program, the following facts about voluntarism in the alcohol field emerge.

- *Volunteers in alcoholism treatment programs that have some public funding include 228 full-time and 2,031 part-time workers. The full-time volunteers primarily provide administrative and support services.*

- *The majority of volunteers in the alcohol field are involved with such projects as crisis lines and help lines.*

Minority Volunteers Focus of Task Force

The Black Task Force of the North Carolina Council on Alcoholism (NCCA) has been successful in devising a number of programs for attracting minority volunteers to the alcoholism field.

Founded in 1975, the task force has conducted public forums, workshops, media campaigns, and conferences, all using the services of volunteers at every stage of planning and organization. According to task force chairman Curtis Hunter, an alcoholism counselor in Charlotte who volunteers his own time to the task force and NCCA programs, "We formed the task force because we needed to move the resources and the services of the State alcoholism effort into the black community. To do this, we decided to recruit volunteers and then train them to train others across the state to work in the alcoholism field."

However, Hunter added, recruiting and keeping good volunteers is not a process that succeeds without planning. "The most important thing I have learned about working with volunteers is that things have to be coordinated," Hunter says. "You need records, organized meetings, and goals. You have to meet regularly. Also you need direction and you need a strong leader—someone who can coordinate, get out front, move into the community, and have an impact."

Moving into the community is exactly what the Black Task Force began doing 7 years ago. Starting with a nucleus of interested people, Hunter asked for and received a meeting with State alcoholism agency officials who offered assistance in getting the task force established. Once a core group was recruited by Hunter and others, the task force met and established priorities for setting up groups in all parts of the State. Originally, Hunter says, most of the volunteers were "human services people"—mental health workers, counselors, and therapists—plus teachers, students, and clergy. Now, he says, the group attracts a large number of the elderly. "A lot of States overlook the elderly as a resource," Hunter says. "But they can be very effective. In many cases, especially among the black community, people are more likely to talk to an uncle or aunt or grandparent if they have a problem than to go to a mental health clinic." In fact, Hunter says, blacks are sometimes resistant to mental health treatment in general. "This is a feeling that can be very high in the black community," he says. "People don't want to be thought of as crazy. They don't want somebody to wonder why they're going to a mental health clinic."

Preliminary indications are that the task force may be making some headway in changing that. Since 1975, task force members have sponsored training sessions throughout North Carolina in an effort to bring information on alcoholism and alcohol problems to those who need it. So far, Hunter estimates, more than 800 persons have been trained and are active in their local communities, and 5 local task forces have been established. In addition, Hunter says, many local volunteers have been successful in linking their volunteer alcoholism organizations with other local groups such as city councils, churches, and clubs. Efforts also have been made to increase black representation on alcoholism councils, he says.

"Alcoholism and mental health are open fields for blacks," Hunter says, "and that is another of the messages that we try to pass on. When we do workshops at colleges, for example, we try to get students invoived. We try to let them know that this is a field they can work in professionally as well as on a volunteer level." According to Hunter, workshops at colleges and universities can be particularly successful because they bring a wide range of individuals together. However, the State task force and various local councils have also found success in working through churches, neighborhood groups, housing organizations, and local government agencies. According to Phil Greenhill, executive director of the NCCA who has worked with the State's black, women's, and clergy task forces since their inception, there are a number of concrete results that can come out of public forums set up by volunteers. "I have seen people go into communities and accomplish a great deal by using only the materials that the citizens' group has on hand," Greenhill says. "For example, you can go into a community and encourage the local church to sponsor a weekly AA meeting. Or, you can set up an ongoing local task force. Or, you can set up an ad hoc group to accomplish certain specific objectives."

The task force on blacks has sponsored a statewide conference on alcohol problems among blacks, held three statewide training workshops, and advocated stronger roles for minorities in the management of health services. It has also developed media materials, brochures, and

public information materials. A poster, intended for statewide distribution, is currently being developed.

As for recruiting volunteers, Greenhill says that three methods have been tried. "Probably the most successful is referral by other volunteers," he says. "If you encourage them, people will often refer their friends and coworkers." Second has been self-referrals, encouraged by advertising and public forums. Third has been active efforts by the black task force to recruit people in colleges and universities, local councils, churches, and alcohol treatment programs to serve as representatives of and liaisons with the task force.

Says Greenhill, "Volunteers are probably the most cost-effective tool we have in the alcohol field. They carry the message about services, create a high profile in the community, and get things done that might not otherwise be accomplished. I think we're just now beginning to see their importance."

—John Small, Staff Writer

RESOURCE LISTING

The following is a partial listing of groups and organizations that may serve as information or technical assistance resources to those seeking more information about volunteers and volunteering. The listing is *not* restricted to those organizations providing alcohol-specific information.

ACTION
806 Connecticut Avenue, NW
Washington, DC 20525

Provides volunteers at the request of sponsoring community agencies; assists with local volunteer project development; gives grant assistance to locally sponsored national emphasis programs and, on a very limited basis, to new innovative programs; supplies materials and technical assistance to volunteer projects. Programs include VISTA (Volunteers in Service to America), Foster Grandparents, RSVP (Retired Senior Volunteer Program), and UYA (University Year for ACTION).

Publications, available free: *Interaction*, a monthly newspaper that provides news and features on ACTION projects, a forum for idea exchange, technical assistance and resource listings; *Synergist*, published three times a year, describes student volunteer projects and lists technical and materials resources; *Americans Volunteer—1974*, a report on a national survey on volunteer activity conducted by the Gallup Poll.

Alcoholics Anonymous
468 Park Avenue South
New York, NY 10016

International self-help organization composed of men and women who share the common problem of alcoholism and who share their recovery with others seeking sobriety. Publications listing available on request.

Alcoholism Council of Greater Los Angeles
2001 Beverly Boulevard
Los Angeles, CA 90057

Publication: Volunteer Information and Training Manual.

American Society of Directors of Volunteer Services
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

Membership organization for directors of volunteer services in health care institutions; annual conference and workshops for volunteer directors.

Publications: *The Volunteer Leader*, a monthly magazine about health care volunteering, available at a cost of $6 per year. *Volunteer Services Administration*, quarterly newsletter, available to members only.

Association for Administration of Volunteer Services
AAVS Administrative Center
Box 426
10214 South Dolfield Road
Owings Mills, MD 21117

Membership organization that promotes volunteer administration as a profession and fosters exchange of knowledge and experience in the field; services include certification and regional meetings and workshops.

Publications: monthly newsletter, *Volunteer Administration*, quarterly magazine.

Association of Junior Leagues
825 Third Avenue
New York, NY 10022

National women's organization that promotes voluntary community service programs in cities throughout the United States, Canada, and Mexico. The association serves in an advisory and coordinating capacity, providing consultation, reference materials, research, program development, and an information center. Contact your local chapter for information on local program areas.

Association of Volunteer Bureaus Inc.
801 North Fairfax Street
Alexandria, VA 22314

Association organized to advocate, promote and assist in the development and advancement of volunteering; helps establish local volunteer coordinating centers; sets standards; and provides for networking.

Publications: *Volunteer Bureau Handbook*, $5; Membership publications.

Association of Voluntary Action Scholars
Box G-55
Boston College
Chestnut Hill, MA 02167

Association of scholars and professionals that seeks to stimulate the efforts of those engaged in voluntary action, research, scholarship, and professional activity and to make the results of these efforts more readily available.

Publications: *Volunteer Administration*, a quarterly journal devoted to the promotion of research, theory, and creative programming of volunteer services; *Journal of Voluntary Action Leadership*, a quarterly journal that disseminates social science research and knowledge; *Voluntary Action Research*, annually; *Citizen Participation and Voluntary Action Abstracts*, quarterly.

Call For Action
575 Lexington Avenue
New York, NY 10022

A telephone service, promoted by broadcast announcements, in which volunteers in nearly 30 cities direct callers to appropriate agencies. Cases are followed and volunteers intercede to help resolve problems when inadequate resources exist.

Publications: *Call For Action Newsletter*, 3 to 4 a year, $6.

Commission on Voluntary Service and Action
United Presbyterian Church, U.S.A.

475 Riverdale Drive, Room 1126
New York, NY 10027

Organizations, church related and private, in the United States and Canada, which sponsor voluntary service projects. Coordinates consultations on voluntary service issues.

Publications: *Invest Yourself*, a catalog of service opportunities for young people.

Membership organization of human service professionals that acts as a clearinghouse for volunteer program opportunities, new training events or materials, and job opportunities for advancement.

Four-One-One
7304 Beverly Street
Annandale, VA 22003

National Clearinghouse on voluntarism that provides comprehensive references for information needed for planning, designing, and managing successful volunteer programs in all areas of human services and community needs.

Fund-Raising Institute
Box 365
Ambler, PA 19002

Package of publications and materials available designed to help nonprofit groups organize and equip groups of volunteer fundraisers; free catalogue-/price list on request.

Independent Sector
1828 L Street, NW
Washington, DC 20036

Corporations, foundations, and national voluntary organizations that seek to preserve and enhance the national tradition of giving, volunteering, and not-for-profit initiative; to educate the public about the role of the independent nonprofit sector.

Publications: *Americans Volunteer 1981*, report on a national survey of volunteers conducted by the Gallup Organization, Inc., $15; list of other publications available on request.

United Way
National Academy for Voluntarism
801 North Fairfax Street
Alexandria, VA 22314

Provides program support and consultation to local United Way organizations; assists in fundraising; administers staff and volunteer development training through the National Academy for Voluntarism; acts as liaison between United Way groups and the Federal Government and nonprofit agencies; provides national media support and produces films, audiovisual materials, and publications. Publications listing available on request.

National Assembly of National Voluntary Health and Social Welfare Organizations
291 Broadway
New York, NY 10007

Fosters intercommunication and interaction among national voluntary health and social welfare agencies in the interests of increasing the impact of the individual agencies and of voluntarism on human needs.

Publications: newsletter, bimonthly; service directory, biennial.

National Council on Alcoholism
Suite 1405
733 Third Avenue
New York, NY 10017

Directs information programs to the health and social service professions, business and labor, and the general public; monitors public policy affecting alcoholics; encourages research in alcoholism; and sponsors and promotes programs on alcoholism and alcohol-related problems of youth, women, and elderly and minority groups. Components of NCA are the American Medical Society on Alcoholism, a national organization of physicians with special experience and interest in the disease; the Research Society on Alcoholism, for scientists working in the field, and the National Nurses Society on Alcoholism. NCA has 230 affiliates that provide a nationwide network of education, information and referral services.

Free catalog of publications on request.

National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane
Rockville, MD 20857

The National Clearinghouse for Alcohol Information provides alcohol-specific literature searches, article reprints, and publications on volunteer topics including *SPECTRUM*, a publication designed to provide women's voluntary organizations with ideas for alcohol problem prevention projects. For a listing of volunteer-related materials available, write Clearinghouse, P.O. Box 2345, Rockville, MD 20852.

The National Center for Alcohol Education develops training and educational materials on alcohol topics. Publications include *Using Volunteers in Your Agency: Trainer Manual* and *Volunteer Program Development Guide*. Write NCAE, 5530 Wisconsin Avenue, Suite 1600. Chevy Chase, MD 20815, for a listing of materials.

The Volunteer Resource Development Program is the focus of a monthly bulletin, *Reaching Out*, on volunteer issues and NIAAA-funded programs. Write Science Management Corporation, 1120 Connecticut Avenue, NW, Washington, DC 20036, for subscription information.

VOLUNTEER: The National Center for Citizen Involvement
1214 16th Street, NW
Washington, DC 20036

P.O. Box 4179
Boulder, CO 80306

Clearinghouse for dissemination of information on volunteer programs. Assists communities and organizations with volunteer activities; maintains 300 affiliated Voluntary Action Centers; sponsors workshops and training courses; provides technical assistance and training services to corporations.

Publications: *Volunteering*, a monthly newsletter; *Voluntary Action Leadership*, a quarterly journal; *Volunteer Readership 1982*, catalog of publications, free.

Volunteers in Probation
A Division of the National Council on Crime and Delinquency
200 Washington Square Plaza
Royal Oak, MI 48067

A national organization advocating citizen participation in court and corrections programs and upgrading of programs in these areas through the exchange of information.

Publications: *VIP Examiner*, a quarterly newsletter covering voluntary activity in courts and corrections programs.

Volunteers of America
National Headquarters Office
3939 N. Causeway Blvd.
Metairie, LA 70002

A national Christian human service organization providing a broad range of community-based services, subsidized housing, and nursing home care to those in need of such assistance throughout the country.

Publications: *The Volunteer Gazette*, the official monthly newspaper of the Volunteers of America, $4.20 a year; *VOAgape*, a quarterly human services publication of the VOA providing a forum for social policy and service delivery issues; subscription information on request.

Compiled by Nancy Johnson, Staff Writer

Corporate philanthropic giving rose to $2.3 billion in 1978.
—The Conference Board

NEWSNOTES

NCAE Training Packages Available Free of Charge

The National Center for Alcohol Education (NCAE) of the National Institute on Alcohol Abuse and Alcoholism has developed a series of training packages available free of charge to trainers, State alcoholism authorities, and groups and organizations that run training programs. The training packages have been used in a variety of settings, including large hospitals, colleges and universities, continuing education departments, and workshops put on by State authorities and other groups.

Training packages include *Counseling Alcoholic Clients, Initial Visit, Management Skills, Planning Alcoholism Services, Programming Community Resources, Services for Alcoholic Women, Training Alcoholism Trainers, Using Volunteers in Your Agency, You, Youth and Prevention,* and *Group Skills for Alcoholism Counselors.*

According to NCAE director Maureen Carroll, the training packages have been enthusiactically received in the field and used in a wide variety of settings. For example, the Volunteer Resource Development Program in Albuquerque (NM) used the Volunteers package in 12 workshops to train 181 people. In three continuing education courses, Fairmont Community College in Fairmont (WV) used staff training packages in conjunction with the West Virginia Department of Health, the Fairmont Council of Churches, and the Marion County Council of Social Agencies. Continuing education courses at colleges and universities throughout the country have also made use of the training packages.

The training packages are available to qualified individuals and groups and further information and order forms can be obtained from the National Center for Alcohol Education, 5530 Wisconsin Avenue, Suite 1600, Chevy Chase, MD 20815.

Conference Board Report Criticized by ALMACA

In a recent issue of *The ALMACAN*, published by the Association of Labor Management Administrators and Consultants on Alcoholism, the Industrial Conference Board's report on "Dealing With Alcoholism in the Workplace" was criticized as "invalid and meaningless." The criticism, authored by Walter Reichman, Ed.D., of the ALMACA Research Committee, said the report was "based on such poor quality research that the findings must be dismissed as invalid and ultimately meaningless." He said the ALMACA Research Committee is officially protesting to the Conference Board "for supporting such inferior research and for releasing the report without review by recognized researchers in the field of occupational alcoholism."

Reichman went on to discuss specifics of the report, charging that the sample size was inadequate and not representative, consisting of only 43 responses to some of the questions. No data was collected, he charged, from union officials or union people in EAP programs, or from the Federal Government. He also criticized the structure of the questionnaires used to gather information, the lack of statistical analysis of data in some cases, and "misrepresentation of statistics."

The ALMACA Research Committee "warns people in the occupational alcoholism field not to make any programmatic decisions or changes on the basis of the Conference Board Report," Reichman wrote. "We are also pointing out the importance of attracting good researchers to this field and the necessity to support the development of research procedures." The article was published in the August 1981 issue of *The ALMACAN.*

ADPA Regional Conference Focuses on Decisions In the '80s

An eastern regional conference of the Alcohol and Drug Problems Association of North America (ADPA) brought together more than 200 health care professionals, planners, and administrators recently in Washington (DC).

The 4-day conference included plenary sessions and workshops on verification and accreditation, employee assistance programs, third-party coverage, Federal and State legislation and funding, women's issues, minority issues, and nurses' issues.

In her keynote address, LeClaire Bissell, M.D., president and chief executive officer of Edgehill-Newport Hospital in Newport (RI) called the 1980s a "decade of decision" and urged those in the alcohol field to "roll up their sleeves" and work even harder to ensure growth. She called for a continued Federal presence in the field and said that a great deal had been accomplished "in a short span of only 10 years." Also, she said, those in the field must begin a constructive dialogue on third-party coverage for alcoholism treatment, which Bissell said, "can give programs some real permanence and move alcoholism and drug abuse into the mainstream of health care."

In a plenary address, Gary Graham, M.D., Medical Director for the Kemper Insurance Group in Long Grove (IL), discussed effects of extending third-party payments for alcoholism treatment. Graham said he was optimistic about the alcohol field and saw the 1980s as an "age of refinement" for alcohol programs. Other plenary addresses focused on ensuring the continuation of sound alcohol and drug abuse services and the future of the alcohol and drug abuse field.

For further information on the conference, contact Roger Stevenson, Executive Director, Alcohol and Drug Problems Association, 1101 15th Street, NW, Suite 204, Washington, DC 20005.

FACTS FOR PLANNING NO. 4 Alcohol Misuse by Adolescents

J. Valley Rachal, L. Lyn Guess, Robert L. Hubbard, and Stephen A. Maisto

Editor's Note: Single copies of Facts for Planning Nos. 1, 2, and 3 are available free of charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, Maryland 20852.

Misuse of alcohol by youths 12 to 17 years old has come to be considered a major social problem in the last 10 years or so. Researchers and many other segments of society are concerned not only about the social consequences of adolescent alcohol misuse but also about its effects upon adolescent psychosocial development (Mayer and Filstead 1980a). Moreover, adolescent alcohol misuse has been seen as an important research area because of the possible relationship between drinking behavior in youth and drinking behavior and alcohol problems later in life.

Despite the wide interest in and concern about adolescent alcohol misuse, it is still difficult to integrate much of the available research into statements that are either theoretically useful or applicable to prevention and treatment programs. One basic and critical problem with research on adolescent alcohol misuse is the failure to define consistently what is being investigated.

In some definitions of alcohol misuse or problem drinking among adolescents, any drinking is referred to as a problem. At the other end of the spectrum, there are definitions that equate alcohol misuse with alcoholism. Marden and Kolodner (1977) noted that, to some researchers, any adolescent drinking is misuse because it is illegal for minors to purchase alcohol. Other researchers have attempted to apply definitions of adult alcoholism to adolescents. However, as Blane and Hewitt (1977) and Schuckit (1978) concluded, the chronic physical and social problems that are part of the generally accepted criteria for establishing adult alcoholism rarely pertain to the behavioral and social correlates of drinking by youths. Young people who misuse alcohol rarely experience the same kinds of severely debilitating problems. (See the technical notes at the end of this article for further discussion of problems in definition.)

1974 and 1978 RTI Surveys: Highlights of Findings on Alcohol Misuse

- The prevalence of alcohol misuse among senior high school students increased slightly, rising 4 percent over a 4-year period; 27 percent of 10th to 12th grade students were misusers in 1974, but 31 percent were alcohol misusers in 1978.
- The prevalence of alcohol misuse was higher among 10th to 12th grade boys than among girls; in 1978, 38 percent of boys were misusers as compared with 26 percent of girls.
- For 10th to 12th grade girls in 1978, the extent of alcohol misuse did not increase significantly with age, contrary to the pattern of misuse among boys in these grades. Among girls, 24.2 percent of 15-year-olds and 24.7 percent of 18-year-olds were alcohol misusers; however, 31.3 percent of 15-year-olds were alcohol misusers while 43.5 percent of 18-year-olds were misusers.
- Students in the 10th to 12th grades who were alcohol misusers drank larger quantities of alcohol and began drinking at earlier ages than did alcohol users. In 1978, more than half of all misusers had their first drink by age 13, compared with one-third of users. Male alcohol misusers in 1978 reported they consumed, on the average, 1.25 oz of alcohol per drinking occasion, compared with 0.26 oz reported by users; among girls, misusers reported average consumption of 0.91 oz per occasion, while users said they drank only 0.17 oz on the average.
- Among 10th to 12th grade students, alcohol misusers more often used marijuana than did abstainers and alcohol users. Nearly all abstainers and the majority of alcohol users did not use marijuana, either in 1974 or in 1978. Among misusers, the vast majority in both 1974 and 1978 reported having used marijuana at least once, and in 1978, over 60 percent of both boys and girls who were alcohol misusers reported using marijuana 11 or more times.
- The extent and frequency of marijuana use among 10th to 12th grade alcohol misusers increased between 1974 and 1978.
- Boys in the 10th to 12th grades classified as misusers reported a greater frequency of negative consequences related to drinking than did girls. However, alcohol misusers—both male and female—were more likely to report negative consequences related to drinking than were users.

Defining the Extent of Alcohol Misuse

This article discusses alcohol misuse based on data furnished by two probability surveys of the Nation's high school students conducted by the Research Tri-

angle Institute (RTI)—the first in 1974 under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the second in 1978 under joint contract to NIAAA and the National Institute on Drug Abuse (NIDA). The survey instrument was a self-report questionnaire, administered by RTI-trained staff to classrooms of students selected through a three-stage stratified nationwide sample of 7th to 12th grade students in 1974 and 10th to 12th grade students in 1978. Findings reported here are limited, for comparative purposes, to 10th to 12th grade students only. (See the technical notes for further information on the survey methodology).

In order to provide information that can serve as a guide to program and policy planning, a consistent and explicit definition of youthful alcohol misuse is needed to clarify its extent. To meet this need, an explicit definition is used throughout this report as a basis for presenting and comparing survey data on the prevalence and correlates of drinking among the Nation's senior high school students.

The definition of alcohol misuse used here was developed by Donovan and Jessor (1978) to distinguish adolescent "problem drinkers" from those who are nonproblem drinkers or abstainers. Two criteria were selected to distinguish types of youthful drinkers -- frequency of drunkenness and frequency and extent of negative consequences resulting from drinking. In order to gauge alcohol misuse, survey respondents were asked how many times during the previous year they experienced negative consequences from drinking in five areas: trouble with teachers or principal, difficulties of any kind with friends, driving "when you've had a good bit to drink," criticism by a date, or trouble with the police. In the 1978 study, a sixth negative consequence area was added: trouble with family members because of drinking. Respondents were also asked how many times in the past year they had been "drunk or very, very high."

Problem drinkers, termed in this report **alcohol misusers**, are students who reported drunkenness at least six times in the past year, or negative consequences two or more times in the past year in at least three of the five areas considered, or both. Although this definition, like the vast majority of other alcohol misuse definitions, is arbitrary, it is explicit and based on objective criteria. It can thus be examined empirically. (See the technical notes for a discussion of the specific questions underlying this definition.)

On the basis of the Donovan and Jessor definition of problem drinking, the 10th to 12th graders in the 1974 and 1978 RTI surveys were classified as abstainers, alcohol users, or alcohol misusers. **Abstainers** were individuals who reported *never* having had more than one or two drinks and drinking no alcohol during the last year. **Alcohol users** were individuals who drank during the past year but who were not defined as misusers of alcohol. (See the technical notes for further details on the classification.)

The overall prevalence rates for abstainers, alcohol users, and alcohol misusers in the 1974 and 1978 samples were similar (table 1). In 1974, 27.1 percent of 10th to 12th graders fell into the misuser category. By 1978, this proportion had risen to 31.2 percent, an increase of 4 percent. The percentage of abstainers varied no more than 1 percent; 17.2 percent of senior high school students reported abstention in 1978, a decrease of 1.4 percent from 1974, when 18.6 percent reported abstention.

An important question con-

Table 1. Abstainers, alcohol users, and alcohol misusers along 10th to 12th graders, 1974 and 1978

Drinker classification	1974	1978
Abstainer	18.6%	17.2%
Alcohol user	54.3%	51.7%
Alcohol misuser	27.1%	31.2%
Sample (*n*)	5,428	4,473

Table 2. 10th to 12th graders classified as misusers because of drunkenness, negative consequences, or both, 1974 and 1978

Misuser criterion	1974	1978
Drunkenness only*	87.4%	93.3%
Negative consequences only	2.4%	1.2%
Drunkenness and negative consequences	10.2%	5.5%

*"Drunkenness only" does not imply that the respondents did not experience "negative consequences," but rather, that they did not meet the negative consequences criterion of "two or more times in the past year in at least three of the five areas."

cerns what proportions of the alcohol misusers were so classified based on the drunkenness criterion, the negative consequences criterion, or the drunkenness and negative consequences criteria combined. In both surveys, most respondents defined as misusers were so classified because of their reports of frequency of drunkenness during the past year. Did those individuals also report some alcohol-related negative consequence in any of the five areas? As table 2 shows, in 1974, the majority (77.6 percent) of individuals classified as misusers because of frequency of drunkenness experienced at least one occurrence of negative consequences in one problem area. In 1978, the comparable figure was slightly lower (69 percent).

Overall rates of alcohol misuse by adolescents mask possible differences associated with various sociodemographic factors, including age, ethnicity, religious affiliation, and socioeconomic status (SES). There were slightly higher proportions of both male and female misusers in 1978 than in 1974. And, as expected, there were more male than female misusers across all sociodemographic variables. In 1978, 37.8 percent of senior high school boys were classified as alcohol misusers as compared with 25.5 percent of the girls.

Table 3 shows the distributions of male and female alcohol misusers as a function of various sociodemographic variables, for the 1978 RTI sample. Misuser status was generally related to age among males. Surprisingly, however, drinking status did not appear to be related to age among females. There were no significant differences in the proportions of female misusers as age increased. Differences in misuser status as a function of ethnicity, religious affiliation, and SES are generally consistent with the literature (Blane and Hewitt 1977). However, extreme caution should be exercised in

Table 3. Male and female alcohol misusers[1] by ethnicity, religious affiliation and socioeconomic status (SES), 1978

	Age[2]									
	15		16		17		18		Total	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Males	31.3	(100)	35.9	(242)	39.6	(373)	43.5	(158)	37.8	(873)
Females	24.2	(124)	23.8	(197)	28.6	(217)	24.7	(77)	25.5	(615)

	Ethnicity[3]							
	Spanish American		White and other		Black		Total	
	%	(n)	%	(n)	%	(n)	%	(n)
Males	29.3	(34)	39.7	(703)	23.6	(39)	37.8	(776)
Females	14.8	(18)	27.9	(576)	10.3	(24)	25.5	(618)

	Religious Affiliation											
	Catholic		Baptist		Other Protestant		Jewish		No religion		Total	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Males	43.6	(263)	37.4	(141)	31.6	(196)	31.4	(16)	40.1	(66)	37.6	(682)
Females	29.3	(276)	18.1	(73)	22.4	(157)	36.4	(16)	31.7	(46)	25.5	(571)

	Socioeconomic status[4]									
	1 (Low)		2		3		4 (High)		Total	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Males	39.5	(34)	35.9	(145)	37.9	(275)	38.5	(322)	37.8	(776)
Females	17.3	(19)	24.9	(149)	26.3	(227)	26.0	(267)	25.5	(618)

[1]Misusers are defined as those experiencing drunkenness at least six times in the past year, negative consequences two or more times in the past year in at least three of the five areas, or both. Several of the cells in the table have a small number of observations; these should be interpreted with extreme caution.

[2]First and last age categories are collapsed: "15" includes respondents 12 to 15 years old, and "18" includes respondents 18 to 24 years old.

[3]Ethnicity variable for 1978 includes American Indians and Orientals in "white" category. Values of this category are thus primarily due to white respondents.

[4]SES is a 10-category variable based on parents' education and occupation; it was collapsed to four categories for this purpose.

interpreting percentages based on small sample sizes, for example, the 16 boys and 16 girls who represent Jewish students.

Correlates of Adolescent Alcohol Misuse

Although descriptive data about alcohol misuse among adolescents are of interest, they do not address the critical questions of how much alcohol misusers drink, where they drink, and the behavioral, social, psychological, and environmental correlates of such drinking. The correlates of adolescent alcohol misuse are a major research area. Clearly, definitions are merely a communication convenience; what is central is how the people who are defined in a particular way behave and the correlates of that behavior. The research to date has been poorly integrated, with some notable exceptions (Akers 1977; Jessor and Jessor 1977; Maddox 1962; Maddox and McCall 1964; Mayer and Filstead 1980*b*; Zucker 1976, 1979; Zucker and Barron 1973; Zucker and Devoe 1975).

The adolescent alcohol misuse literature does catalog correlates of the various definitions of misuse that have been used. These include drinking behaviors, other drug use, sociodemographic factors, attitudes and knowledge, environmental factors, and parent and peer influence (Barnes 1980; Marden and Kolodner 1977; Mayer and Filstead 1980a; Walker et al. 1978). Data from the 1978 study has been used to investigate selected correlates of the misuse of alcohol among adolescents and, where appropriate, to compare the findings with the 1974 RTI study and with other research. This approach takes advantage of a major source of new data. Our hope is that the descriptive information and basic data will form a foundation for more intensive analyses that can contribute to the development of theory and to policy decisions about adolescent alcohol misuse.

Behavioral and Psychological Correlates of Drinking. One aspect of any definition of alcohol misuse is the consistency of the researcher's or clinician's definition with the labeled person's perception of his or her behavior. In the RTI studies, respondents who were drinkers were asked how much of a problem drinking had been for them in the past year. In both years, more misusers—both girls and boys—perceived their drinking to be at least a mild problem the past year than did users. However, the vast majority of misusers felt that drinking had not been a problem.

Alcohol misusers appear to begin drinking at an earlier age than users, and males generally begin drinking earlier than females. In both 1974 and 1978, misusers reported that they had had their first drink at younger ages than did users. Over half of the misusers said they had had their first drink by the time they were 13 years old, compared with about one-third of the users. The 1978 data for age at first drink did not show significant variation from the 1974 findings for males or females.

There are considerable differences in current drinking between alcohol users and misusers. Table 4 shows the means of daily ethanol consumption of beer, wine, distilled spirits, and all beverages combined for both groups. The finding that misusers drank substantially more than alcohol users was consistent across sex and for the 2 study years.

The drinking levels of those in the alcohol user and misuser classifications in the 1978 study are examined in table 5. A clear relationship between higher levels of alcohol consumption and misuser classification emerges. "Heavier" drinkers are students who reported they drank at least once a week and large amounts on each occasion. Refer to *Facts for Planning* No. 2 for further information on "RTI's Drinking Level" typology (Lowman 1981/82). For males, about 85 percent of those classified as "heavier" drinkers were classified as misusers. For females, about 88 percent of the "heavier" drinkers were classified as misusers. It thus appears that alcohol misuse is directly and strongly related to levels of alcohol consumption.

The RTI data also showed that alcohol misusers reported relatively heavy marijuana use. Virtually all abstainers reported that they had not used marijuana during the past 6 months. The majorities of male and female alcohol

Table 4. Ethanol consumption by beverage, male and female users and misusers, 1978

Sex and drinker classification	*Mean daily ethanol consumption (in ounces)**			
	Beer	Wine	Distilled spirits	Total consumption
Male alcohol user (n = 969)	0.13	0.05	0.07	0.26
Male alcohol misuser (n = 776)	0.76	0.14	0.35	1.25
Female alcohol user (n = 1342)	0.05	0.05	0.08	0.17
Female alcohol misuser (n = 618)	0.35	0.21	0.35	0.91

*Mean daily ethanol consumption is based on reports of the frequency with which a beverage is consumed and the amount typically drunk on those occasions.

Table 5. Male and female alcohol users and misusers by drinking levels, 1978

Sex and drinker classification	Drinking level					
	Infrequent	Light	Moderate	Moderate/ Heavier	Heavier	Total
Male alcohol user	96.7%	91.6%	68.5%	41.0%	14.8%	53.0%
Male alcohol misuser	3.3%	8.4%	31.5%	59.0%	85.2%	47.0%
Male sample (n)	122	310	340	420	458	1650
Female alcohol user	97.4%	91.7%	73.4%	39.3%	12.3%	66.2%
Female alcohol misuser	2.6%	8.3%	26.6%	60.7%	87.7%	33.8%
Female sample (n)	228	503	458	422	219	1830

users in 1974 and 1978 reported that they had not used marijuana during this time; among males, 67 percent in 1974 and 65.8 percent in 1978 did not use marijuana, while among females, nonusers of marijuana amounted to 65.4 percent in 1974 and 67.1 percent in 1978. In contrast, in 1974, 74.7 percent of the male misusers reported using marijuana at least once in the past 6 months, with 44.5 percent using this drug at least 11 times. In 1978, these percentages were 78.8 percent and 62.4 percent, respectively. Similarly, in 1974, 81.9 percent of the female misusers reported using marijuana at least once, and 44.5 percent reported using it 11 or more times. In 1978, the data showed that 86.6 percent of the female misusers used marijuana at least once, and 67.2 percent reported using it at least 11 times.

Alcohol-Related Consequences. A common criticism of the definitions of problem drinking or alcohol misuse is that the alcohol-related problems on which these definitions are based are poorly defined and measured. It has been argued, for example, that frequently an adolescent is labeled a problem drinker as a result of few alcohol-related negative events (O'Gorman et al. 1977).

To further examine this, the five problem areas assessed in the 1974 and 1978 studies were analyzed to compare male and female alcohol users and misusers. The percentages of respondents who reported at least one occurrence of a problem during the past year were computed. Among respondents reporting at least one occurrence of a given problem, the percentage who reported only one occurrence was also computed. These analyses are summarized in table 6 for male and female users and misusers in 1974 and 1978 for each of the five problem areas.

The proportion of *misusers* who reported at least one occurrence of any of the five problem areas was substantially higher than the proportion of *users* who

Table 6. Male and female alcohol users and misusers and the occurrence of problems in the five problem areas, 1978 [1]

Sex and drinker classification	Problem area related to drinking				
	Trouble with teachers or principal	Difficulties with friends	Driving after having a "good bit" to drink	Criticism from a date	Trouble with the police
Male alcohol user	1.2%	12.3%	20.6%	8.2%	4.1%
Male alcohol misuser	9.5%	34.2%	59.4%	20.8%	25.4%
Male sample (n)	1,739	1,738	1,737	1,730	1,739
Female alcohol user	0.97%	12.8%	11.9%	9.1%	2.4%
Female alcohol misuser	4.9%	36.2%	41.7%	18.0%	11.5%
Female sample (n)	1,956	1,955	1,955	1,946	1,956

[1]Numbers represent the percentage of alcohol users (or misusers) in the sample reporting at least one occurrence of alcohol-related trouble during the past year.

did. This, in part, is to be expected because one way a respondent could be defined as a misuser was through reports of alcohol-related problems. However, these data show much more clearly than the definition would suggest that misusers have disproportionately experienced alcohol-related negative consequences. Second, there are differences in proportions as a function of the problem area, which held true for both users and misusers. For some problem areas, only a small minority of misusers reported at least one occurrence; but for others, more than half reported such problems. These conclusions pertain to both years and both sexes.

There also was a wide range in the proportions of one-time-only events in the problem areas. In 1974, of the 12.9 percent of the male misusers who reported at least one occurrence of trouble in school, more than half reported only one such occurrence. Data for females in 1974 and for males and females in 1978 were similar. However, among the 68 percent who reported that they drank and drove at least once, 91.1 percent drank while driving more than once. The data also show that, for both users and misusers in 1974 and 1978, males generally reported a higher frequency of problem occurrence.

Environmental Correlates. Thus far, we have concentrated on drinker status and the alcohol-related behaviors, perceptions, and consequences for individuals classified as a particular type of drinker. Another question concerns the environment in which drinking (or abstinence) occurs. This is a particularly critical area of investigation for policy decisions because of the potential utility of modifying the environment to prevent problem drinking. Accordingly, a considerable portion of the research on the correlates of adolescent alcohol use and misuse has focused on environmental factors.

Two key variables stand out: peer and parental influences. There seems to be an unusual degree of agreement in the research literature about the importance of these two factors. Walker and colleagues (1978) argued that parental attitudes toward drinking are the best predictors of adolescent drinking. In summarizing his extensive review of peer influences on adolescent alcohol use, Barnes (1980) stated that all of the studies that have investigated peer influence and alcohol use have found a relationship between them. The 1974 and 1978 RTI studies were consistent with the literature and across sex and year divisions, because adolescent drinker status was directly related to parents' and peers' attitudes toward drinking and drinking practices.

Another important variable is the setting in which drinking occurs. Although some reviewers (Marden and Kolodner 1977) have alluded to the contribution of the setting to adolescent drinking behavior, there has been little systematic investigation of the setting to match studies done with older drinkers (Harford 1979). Several drinking settings were examined, using the 1974 and 1978 study data, and contexts of drinking were found to be related to drinker status. Again, the data were consistent across sex and year divisions. Investigation of adolescent alcohol misuse as a function of drinking context is certainly warranted.

Implications

The results of the 1974 and 1978 studies are generally consistent and in agreement with the literature in showing differences between users and misusers in a variety of factors, including drinking behavior and personal and environmental correlates of drinking. The stability of the data suggests that the descriptive, univariate findings discussed here have validity.

It is clear that substantial numbers of adolescents drink and many of these adolescents engage in high-risk behaviors when they consume alcohol. This information is critical for the policymaker because it identifies current and potential intervention targets. In order to expedite the development of effective intervention programs, further attempts at integrating these correlational data into theory are required. Substantial progress in this direction has been made through use of the RTI study data by Jessor and his colleagues (Donovan and Jessor 1978; Jessor et al. 1980). More progress will be made as Jessor's problem-behavior theory and other theories are tested further, and developed and refined. More work in these areas is needed—work that may ultimately result in effective prevention and treatment efforts through a fuller understanding of adolescent drinking.

Technical Notes

RTI Survey Methodology and Procedure

National probability surveys of adolescent drinking practices were conducted by the Research Triangle Institute (RTI) in 1974 and 1978, the former under contract to NIAAA and the latter under joint contract to NIAAA and the National Institute on Drug Abuse (NIDA).

Methods and Trend Data. Similar sampling methodologies and questionnaires were used in both surveys to provide information on trends in drinking practices as related to demographic, attitudinal, and personality characteristics; the frequency, quantity, contexts, and consequences of drinking; the perceived or reported influence of friends and peers; deviant or antisocial behavior; and the use of drugs in addition to alcohol. However, only senior high school students (10th to 12th grades) were sampled in

1978; both junior and senior high school students (7th to 12th grades) were sampled in 1974.

Sampling Strategy. In 1978, RTI employed a three-stage stratified sampling strategy. The first stage involved selecting a probability sample of all counties in the 48 contiguous States and the District of Columbia, stratified by geographic region and community size. A second-stage probability sample was taken of all high schools in each county selected. At least one high school was chosen from each county and more than one from large counties. Finally, a probability sample of homerooms, one for each grade in school, was taken from the sample of high schools selected in the second stage. In 1974, the second and third stages were combined in a one-stage probability sample of homerooms stratified by three grade ranges (7-8, 9-10, 11-12). In both years, questionnaires were self-administered by students grouped in homerooms or classes. Instructed and supervised by RTI-trained staff, students were assured that their responses would be anonymous and confidential. Using these procedures, 13,112 usable questionnaires were obtained from junior and senior high school students in 1974 and 4,918 from senior high school students in 1978. There were 839 students surveyed in 1974 when they were in the 7th and 8th grades who were surveyed again in 1978 (a panel study).

Representativeness. In the 1978 study, some of the original, randomly selected sampling units were replaced, using probability measures. If the assumption is valid that replacement units are equivalent to the original ones, the final sample in 1974 represents a 72.7 percent "overall response rate" (the homeroom response rate multipled by the within-classroom response rate). In 1978, the "overall participation rate" in the final adjusted sample is 85 percent (the proportion of schools participating multiplied by the proportion of students participating). In the panel study, 56 percent of the 1974 7th and 8th grade sample were selected randomly to participate in the 1978 panel.

The RTI samples were not representative of all the Nation's adolescents. Neither high school dropouts nor absentees were sampled. Both of these subgroups may manifest different drinking patterns from those that characterize the in-school high school students. Further, inner city students and members of the ethnic groups other than "white" or "black" were probably undersampled in 1978. Nonetheless, the sample is representative of the majority of the Nation's senior high school students at that time. More detailed discussions on sampling procedures and evaluations of sample validity are contained in the RTI final reports and in other references listed at the end of this section.

Statistics: Unweighted Data and Percentages

In the first three *Facts For Planning* reports of RTI findings on adolescent drinking practices, weighted percentages were used in order to estimate the number of youths in the Nation who in 1978 were drinkers, by various criteria (Lowman 1981, 1981/82*a*, 1981/82*b*). For convenience in analytical procedures, all analyses herein are based on *unweighted* sample values. The distributions of weighted and unweighted values are not significantly different (Rachal et al. 1980*b*).

Percentages are based on all cases that have analyzabie data, not the total samples.

Findings presented in the tables in this article are mean, or average, percentages. Estimates of standard error produced by national probability sampling can be used to establish 95 percent "confidence intervals" for mean percentages, low and high points of a percentage range within which estimates of national prevalence based on a sample are likely to be "true" 95 percent of the time. The use of national estimates to make rough estimates of local prevalence should be based on a confidence interval, in order to establish a maximum and minimum limit within which the possible number of cases may fall. For information on how to calculate confidence intervals, see Appendix B in RTI's report on the 1978 survey (Rachal et al. 1980*a*).

Problems in Defining Alcohol Misuse in Youth

According to Bacon (1976), the failure to adequately define alcohol misuse in youth is a result of several factors: the assumption that drinking per se is a problem; failure to recognize the complex social factors involved in defining behavior problems; failure to remember that the relationship between current and later alcohol problems cannot be assumed, but is a subject for empirical investigation; failure to remember that problems are specific and time related; the assumption that problem areas are interchangeable; and the failure to define empirically what alcohol-related problems are, i.e., how directly alcohol is associated with the experience of a particular event that is defined negatively.

Mayer and Filstead (1979) argued that many difficulties might be overcome by empirically defining adolescent alcohol misuse. Their approach was to construct a 14-item scale based on previous investigations of adolescent alcohol misuse, choosing variables that had been shown empirically to be the best discriminators between users and misusers of alcohol. The 14 items included information on frequency and recency of drinking alcohol; motivations for drinking; and the environmental, social, and psychological correlates of drinking. Validation of this scale (called the Adolescent Alcohol Involvement Scale, or AAIS) suggests that it could be used productively to arrive at some consistency in definition across investigations.

Questions Underlying the Definition of Alcohol Misuse

The definition of problem drinking developed by Jessor and Donovan (1978) is the definition adopted here for alcohol misuse; that is, youth who report drunkenness at least six times in the past year, negative consequences two or more times in the past year in at least three of five areas considered, or both.

Donovan and Jessor (1978) used two sets of criteria to define problem drinking. The first criterion set involved frequency of drunkenness during the last year. In both the 1974 and the 1978 studies, respondents were asked, "During the last year, about how many times have you gotten drunk or very, very high?" The response categories were none, once, 2 or 3 times, 4 or 5 times, 6 to 10 times, once a month, twice a month, and once a week or more.

The second criterion set concerned the experience over the last year of alcohol-related negative consequences in areas that are relevant to adolescents in the United States. In both surveys respondents were asked, "During the past year, how many times have the following happened to you?" Negative consequences items were "You've gotten into trouble with your teachers or principal because of your drinking," "You've gotten into difficulties of any kind with your friends because of your drinking," "You've driven when you've had a good bit to drink," "You've been criticized by someone you were dating because of your drinking," and "You've gotten into trouble with the police because of your drinking."

In the 1978 study, a sixth negative consequence area was added—"You've gotten into trouble with your family because of your drinking." For the first five problem area items, frequency of occurrence responses included none, once, 2 or 3 times, 4 or 5 times, 6 to 9 times, and 10 or more times. The criteria of the responses to the drunkenness and five negative consequences questions (available for both

the 1974 and 1978 studies) were used to define alcohol misusers. (Findings on problems with family related to drinking will be reported in a future *Facts For Planning* article.)

In using this definition in their analyses of the 1974 data, Donovan and Jessor (1978) compared it with two other definitions of alcohol misuse. One definition emphasized drunkenness and the other emphasized the occurrence of negative consequences. Analyses showed that all three definitions similarly distinguished alcohol users from misusers on a variety of psychosocial factors.

In RTI's final report to NIAAA and NIDA (Rachal et al. 1980a), the relationship of various misuse measures is examined in Appendix C, which evaluates the reliability and validity of the survey data and measures.

Missing Data

Students who could not be classified due to missing or inconsistent information and individuals who were former drinkers but current abstainers were treated as missing data and were excluded from the analyses. The "former drinkers" reported having more than one or two drinks in their lifetimes but consuming no alcohol during the past year. In 1974, the number of such missing cases was 507 (9.5 percent), and in 1978, the number of missing cases was 445 (9 percent).

In the analyses of alcohol misuse, any total sample size listed as fewer than 5,935 in 1974 or fewer than 4,918 in 1978 results from cases missing in the drinker classification variables and from missing data in the other variables in the analysis.

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*These publications are available for purchase from the National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161.

This article is excerpted from Chapter VII of *The Extent and Nature of Adolescent Alcohol and Drug Use: The 1974 and 1978 National Sample Studies*, the final report of the Research Triangle Institute (RTI) on the results of a 1978 survey conducted under contract to the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. J. Valley Rachal, L. Lyn Guess, and Robert L. Hubbard are on the staff of Research Triangle Institute, Research Triangle Park, North Carolina. Stephen A. Maisto is on the staff of the Department of Psychology, Vanderbilt University, Nashville, Tennessee.

FACTS FOR PLANNING NO. 5 Adolescent Marijuana and Alcohol Use

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Author's Note: Throughout this report, the term marijuana is used generically to refer to hashish as well as marijuana, both products of the common hemp plant Cannabis sativa. *(See the technical notes for information on the two cannabis products.)*

Alcohol is the psychoactive substance used by the largest number of youth in the United States. Its use has been found to be correlated with many problem behaviors; however, the use of other psychoactive drugs, especially marijuana, also is extensive among youth and poses problems of considerable concern.

A strong association has been demonstrated to exist between levels of alcohol use and the extent to which other psychoactive drugs are used (Lowman 1981/1982a). A survey conducted by the Research Triangle Institute (RTI) also shows an especially marked correspondence between the prevalence of two of the most popular drugs among American youth—marijuana and alcohol. For instance, 36 percent of moderate drinkers and 63 percent of heavier drinkers reported using marijuana during the previous month as compared with 9 percent of infrequent drinkers who did so (Lowman 1981/1982a).

The RTI national probability survey of adolescent alcohol use and its correlates was conducted in the spring of 1978 under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) with additional funding from the National Institute on Drug Abuse (NIDA). Self-report data were collected through questionnaires administered to a representative sample of 10th to 12th grade students. Conclusions of this study are consistent with the results of other national surveys conducted at about the same time (for example, Fishburne et al. 1980 and Johnston et al. 1979). The 1978 survey is similar to one conducted by RTI in 1974 (See the technical notes in *Facts for Planning No. 4 page 66* for background information on the 1974 and 1978 surveys).

This article presents RTI data that show how patterns of marijuana use are generally compara-

Highlights of the 1978 RTI Survey

- Half of all senior high school students had used marijuana at least once.
- One of five senior high school students had used marijuana at least once a week in the previous 6 months.
- About 17 percent of senior high school students reported having used marijuana 100 times or more.
- One of 25 senior high school students reported they used marijuana daily.
- Eighteen percent of senior high school students reported they had given up marijuana use entirely.
- Almost 30 percent of senior high school students reported they sometimes used marijuana and alcohol together; 7 percent used them together "all the time."
- Seventy-one percent of senior high school students who were heavier drinkers sometimes used marijuana and alcohol together; only 5 percent of infrequent drinkers reported such combined use.
- The national prevalence of marijuana use among senior high school students appears to have leveled off, with no dramatic increase from 1974 to 1978.
- Alcohol and marijuana use followed similar patterns among senior high school students in 1978 in the following areas:
  - —Senior high school students in suburban areas were more likely to use both alcohol and marijuana than were students in other areas..
  - —More 10th through 12th grade boys than girls used both alcohol and marijuana.
  - —The prevalence of both alcohol and marijuana use among senior high school students decreased as religiosity increased.
  - —The prevalence of both alcohol and marijuana use was higher among senior high school students with more spending money.
  - —Senior high school users of both alcohol and marijuana were more likely than nonusers to report lower grades.
  - —The number of both alcohol- and marijuana-related problems reported by senior high school students increased with frequency of use.
  - —Reported first use of both marijuana and alcohol peaked between the ages of 13 and 15 years.
- Patterns of use for marijuana differed from alcohol use patterns among senior high school students in 1978 in the following areas:
  - —The prevalence of weekly marijuana use was the same for students 15 years old as for those up to 18 years of age. In contrast, the number of students who reported weekly alcohol use increased with age.
  - —Weekly use of marijuana was least prevalent among students who attended senior high schools in rural areas, while weekly use of alcohol was most prevalent among students in these same rural areas.

ble to those of alcohol use. Findings also reveal the extent of combined marijuana and alcohol use, pointing to potentially serious problems that face youth who are simultaneous users.

Patterns of Marijuana Use

Kandel (1980) reviewed the considerable literature on drug use among youth and concluded that regular daily marijuana use among adolescents is now more prevalent than daily drinking, the use of marijuana and other drugs has increased dramatically over the past decade, research emphases and concepts have changed to view drug and alcohol use as part of complex social processes rather than as extremely deviant or abnormal behavior, and longitudinal research on the developmental process of use is needed.

While analyses of longitudinal data can provide meaningful predictors of potential alcohol and drug problems, prevalence data collected at a single point in time provide information on the extent of use and the problems related to it that is essential for planning purposes. Of immediate utility to planners and policymakers is information on the prevalence of alcohol and marijuana use among different subgroups of the population. Such information can be used in assessing program and policy needs, as well as in estimating the resources required to address these needs.

Trends. An analysis of 1975 to 1980 trends in the prevalence of drug use among the Nation's high school seniors was conducted by the University of Michigan's Institute for Social Research (ISR). The ISR study, based on a series of annual surveys, revealed a rapid rise in the annual and past-month prevalence of marijuana use between 1975 and 1978. The study also showed a recent, dramatic leveling off in the prevalence of marijuana use among 12th grade students. The RTI data on 10th to 12th grade students reveal a slight increase (4 percent) in reported marijuana use between 1974 and 1978. Consistent with the ISR findings, the 1978 RTI survey showed no evidence of an increase in use during the 6 months prior to the survey.

Table 1. Patterns of marijuana use in the past six months for 15-18 year olds, 1978

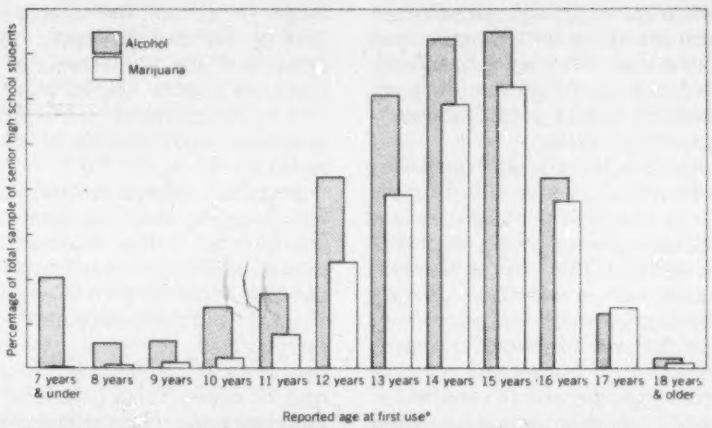
Six-month pattern of marijuana use	Age				
	15	16	17	18	Total
Never used	53.7%	51.4%	45.9%	46.3%	49.3%
Used but not in past six months	8.2	9.6	12.0	11.0	10.3
Used less than once a month	6.6	9.7	11.0	10.2	9.6
Used one to three times a month	9.6	8.8	8.3	9.6	8.9
Used at least once a week	21.9	20.5	22.9	22.9	21.9
Total	100.0	100.0	100.0	100.0	100.0
Sample (n)	889	1560	1507	705	4661

Note: Table 1 reproduces table VI.8 in the RTI final report (Rachal et al. 1980a).

RTI findings about potential use of marijuana reinforce the ISR findings. Potential users of a drug were defined by RTI researchers as students who reported they had already tried it, who reported they had not tried it but would like to, or who expressed uncertainty about whether or not they would like to try the drug. Using this definition, there were only 5 percent more potential than actual users of marijuana among 10th to 12th graders in 1978; 56 percent were identified as potential users; 51 percent had tried marijuana at least once (Rachal et al. 1980a). This was not the case for other psychoactive drugs about which RTI survey participants were questioned. For example, there were twice as many who were potential users of cocaine (23 percent) as there were youths who had ever used cocaine (10 percent).

Frequency. Information on the frequency of marijuana use within the 6 months prior to the survey was used to assess patterns of marijuana use (table 1). Of those senior high school students who provided information about their marijuana use in that 6-month period, over half (51 percent) reported having used marijuana at least once, and one in five (22 percent) reported having used marijuana at least once a week. Nine percent reported using marijuana at least once a month, and 10 percent said they used it less than once a month. About 10 percent had used marijuana at one time but not in the past 6 months.

In reporting on lifetime use, 16 percent of the senior high schoolers reported they had used marijuana 100 times or more; 7 percent said they had used it 1,000 times or more. Four percent of the senior high school students surveyed reported daily marijuana use during the previous month; 16 percent reported they had used it at least 7 days during the previous month. Approximately 18 percent of the 1978 respondents reported they usually kept their own equipment,



*Each bar in figure 1 represents the percentage of the total 4,918 respondents who reported first use of the drug at the age indicated. The twelve bars that represent age categories for each drug do not sum to 100 percent because respondents who had never tried the drug, couldn't remember when they did, or who did not answer the question are excluded from the percentage distribution for each drug in figure 1. (Twenty-five percent of the respondents are excluded from the alcohol distribution; 50 percent from the marijuana distribution.)

Figure 1. Age at which alcohol and marijuana were first used, as reported by senior high school students, 1978

such as marijuana papers or "hash" pipes.

The RTI data indicate that exposure to marijuana use does not necessarily initiate an irreversible process of increasing drug involvement. Despite evidence of widespread prevalence, 17 percent of the senior high school students sampled in 1978 reported they had given up marijuana use entirely. About 21 percent responded "yes" to a question that asked if they found themselves making new friends "because old friends were using too much marijuana or hashish."

Correlates

As with alcohol use, marijuana use varies for different subgroups of the senior high school population. In most cases, these variations follow the same pattern as for alcohol use; in some instances, they differ.

Age. As expected, higher prevalence of lifetime marijuana use occurs among older students. However, about the same percentage of each age group reported weekly marijuana use (table 1). This contrasts with weekly alcohol use, which increases with age among both sexes (Lowman 1981).

Ethnicity. Other than lower prevalence among Hispanic youth, no ethnic differences were found in marijuana use. Only 43 percent of Hispanic senior high school students had ever used marijuana as compared with 54 percent of non-Hispanic white students (Rachal et al. 1980a). Prevalence of marijuana use was comparable among black and white students. In contrast, the prevalence of alcohol use consistently was found to be lower among black than white students (Lowman 1981).

Sex. About 54 percent of senior high school boys and 48 percent of girls reported they had ever used marijuana; 26 percent of boys and 18 percent of girls used marijuana weekly (Rachal et al. 1980a). This pattern parallels the pattern of greater and more frequent alcohol use among 10th to 12th grade boys than girls (Lowman 1981).

Age at onset. In the 1978 survey, senior high school students were asked to report the age at which they first used marijuana and alcohol. Their responses (figure 1) show that initial use of both alcohol and marijuana peaked at 14 and 15 years of age. At these ages, 29 percent had their first drink (not just a "sip or taste") and 23 percent tried marijuana for the first time.

Only 3 percent of the students surveyed in 1978 reported using marijuana before they were 12 years of age; 14 percent said they had their first drink before age 12. A major surge in reported first use both of alcohol and marijuana occurred at 12 years of age; 8 percent of students sampled used alcohol for the first time and 5 percent used marijuana at the age at which most students enter junior high school.

Community size. Both lifetime prevalence and weekly marijuana use were lowest among senior high students in rural areas and highest among students in suburban areas. Approximately 42 percent of students who went to schools in rural areas had used marijuana at least once; 18 percent used it weekly. In suburban areas, 60 percent of the students had ever used marijuana, and 27 percent reported weekly use (Rachal et al. 1980a).

Findings on variations in alcohol use related to community size indicated that students who attended schools in suburban areas were at high risk for alcohol use on a number of measures. Surprisingly, reported weekly heavy alcohol use was highest among students who attended senior high school in small communities (Lowman 1981). However, lifetime prevalence of alcohol use was lowest in rural areas, as was the lifetime prevalence of marijuana use.

School size. The larger the school, the more common were experiences with and weekly use of marijuana. Only 43 percent of senior high school students who attended schools with enrollments of 500 or fewer students had ever used marijuana and only 15 percent used it weekly. In senior high schools with enrol-

lments of 2,500 or more students, 60 percent of students had ever used marijuana and 30 percent used it weekly (Rachal et al. 1980a). No comparable relationship exists between the prevalence of alcohol use and school size. Although the relationships between community and school size and the extent of marijuana use are strong, the generality of these findings may be limited because of some school systems' nonparticipation, particularly in large urban areas. (See the technical notes in *Facts for Planning No. 4*, page 67, for a discussion of the representativeness of the sample.)

Socioeconomic status and religiosity. Both alcohol and marijuana use decreased with increasing religiosity, measures of which were based on responses to questions about the importance of religious beliefs and activities (Rachal et al. 1980a). Socioeconomic status, as represented by parents' reported education and occupation, was not related to prevalence of either alcohol or marijuana use.

Weekly spending money. Some factors may be viewed either as causes or consequences of marijuana use. The more money students had to spend, the more likely they were to report experience with marijuana and to report weekly use. Twenty-seven percent with more than ten dollars available reported weekly use compared to less than 12 percent of those who had less than three dollars available (Rachal et al 1980a). This suggests that more discretionary income increases the risk that marijuana will be used. On the other hand, students who use marijuana may have obtained their higher amounts of money by stealing or by selling some of their marijuana. There is a similar relationship between drinking levels and discretionary income. About 57 percent of heavier drinkers, as compared with 41 percent of the total sample, had more than $10 a week to spend. Only 9 percent of heavier drinkers had $3 or less in weekly spending money.

Grades in school. Experience with and frequency of both marijuana use and alcohol use are related to lower grades (Rachal et al. 1980a). Only two of five students who reported getting mostly As or Bs had ever used marijuana, while two of three students who reported getting mostly Cs, Ds, and Fs reported at least 1 use. Weekly marijuana use was reported more often by students who reported lower grades (38 percent) than by students reporting higher grades (13 percent). Similarly, only 8 percent of senior high school students who usually got As and Bs were heavier drinkers; 25 percent of students who usually got Cs, Ds, and Fs were heavier drinkers.

Heavier marijuana users reported that their grades got worse because of marijuana use. However, it may also be the case that students who are doing badly in school use marijuana and/or alcohol to cope with stress and the consequences of poor academic performance. (See technical notes on the pharmacology and hazards of marijuana use.)

Problems related to marijuana use. As the level of marijuana use increased, more marijuana-related problems were reported by students in the 1978 RTI survey (Rachal et al. 1980a). Fifteen percent of all students reported problems in controlling moods, and 17 percent had problems in concentrating when using marijuana. Among monthly and weekly marijuana users, about two in five reported a problem with concentration and about a third reported an inability to control moods when using marijuana. Weekly users were far more likely than nonusers and less heavy users to report absenteeism (32 percent), worsening grades (21 percent), police contacts (11 percent), and trouble with parents (34 percent) attributed to marijuana use. In addition, more types of problems

Table 2. Patterns of marijuana use in the past six months in each drinking level among senior high school students, 1978[1] (Percentage distribution)

Six-month pattern of marijuana use	Drinking level[2]						
	Abstainers	Infrequent	Light	Moderate	Moderate/heavier	Heavier	All students
Never used	86.8	75.5	52.0	35.3	23.4	16.1	49.3
Used but not in past six months	7.3	10.2	14.0	13.1	10.3	7.2	10.3
Used less than once a month	1.5	6.7	14.6	13.8	10.3	12.0	9.6
Used one to three times a month	1.3	4.3	8.6	13.7	15.1	11.5	8.9
Used at least once a week	3.1	3.4	10.8	24.1	40.9	53.2	21.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Sample (n)	936	538	868	804	835	680	4661

Interpret the statistic in the upper left-hand corner as follows: About 87 percent of senior high school students who abstain from alcohol use have never used marijuana.

[1]Table 2 reproduces table VI. 18 in the RTI final report (Rachal et al. 1980a: 120).

[2]See the technical notes for definitions of the drinking levels.

were reported by weekly marijuana users. Over half of the weekly users reported problems in two or more areas because of their marijuana use.

A comparable pattern of relatively more drinking-related negative consequences has been observed to occur among students who reported higher levels of alcohol use in the RTI surveys (Lowman 1981/1982a, Jessor, Chase, and Donovan 1980).

Simultaneous Alcohol and Marijuana Use

One of the reasons that patterns of alcohol and marijuana use are comparable among students in the RTI surveys is that the use of both of these two drugs is highly associated. Many of the heavier alcohol users were also heavier marijuana users. About half of the students who were moderate to heavier drinkers reported use of marijuana within the last month as compared with 10 percent of abstainers, infrequent, and light drinkers (Lowman 1981/82a). It should not be surprising, therefore, that similar attributes and behavior patterns characterize these two overlapping subgroups.

In *Facts for Planning No. 2* (Lowman 1981/82a), the extent and frequency of marijuana use was shown to rise dramatically at each of six levels of increasing alcohol consumption. (See the technical notes for definitions of the six drinking levels.) Table 2 shows that in 1978 over half of the senior high school students who were heavier drinkers reported they used marijuana at least once a week, compared with only 3 percent of alcohol abstainers who did so. While only 16 percent of heavier drinkers had never used marijuana, 76 percent of infrequent drinkers and 87 percent of alcohol abstainers never had.

Although it is common knowledge that marijuana and alcohol are often used together, the nature, extent, and consequences of these use patterns have not been thoroughly explored. Research on the effects of combined marijuana and alcohol use indicates that the duration and magnitude of effects vary widely, depending on the strength of both substances, the amount consumed, the time interval during which they are consumed, and the type of effects measured, as well as large individual differences in physiological response to combined use (NIDA 1980a). Some people, for instance, have been reported to experience intense nausea or a radical drop in heart rate (NIDA 1980b). Research among human subjects, while limited, does indicate that combined use, when alcohol is consumed at socially typical levels, results in a greater reduction in "reaction time, cognitive performance, standing steadiness, and psychomotor coordination" than occurs in response to use of either drug alone (NIDA 1980b).

Table 3 shows that approximately 29 percent of the senior high school students surveyed by RTI in 1978 reported they sometimes used marijuana and alcohol together. Ten percent of 10th to 12th grade students reported using the two drugs together about half the time, 7 percent nearly all the time. Rates of simultaneous use were markedly higher for heavier drinkers. For example, 71 percent of students classified as heavier drinkers reported they had ever used the two drugs together as compared with 5 percent of students classified as infrequent drinkers. Twenty five percent of heavier drinkers used marijuana and alcohol nearly all the time, as compared with fewer than 1 percent of infrequent drinkers (table 3).

Table 3. Combined marijuana and alcohol use patterns in each drinking level among senior high school students, 1978 (Percentage distribution)[1]

Pattern of combined use	Drinking level[2]					
	Infrequent	Light	Moderate	Moderate/heavier	Heavier	All students
Never use marijuana	76.7	55.1	37.2	24.9	14.8	50.4
Never use marijuana with alcohol	18.8	28.3	30.3	20.7	13.9	20.2
Use together less than half the time	3.2	10.6	16.7	21.9	19.7	12.0
Use together about half the time	0.5	3.5	8.8	21.3	26.5	9.9
Use together nearly all the time	0.8	2.5	7.0	11.2	25.1	7.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Sample (n)	373	851	791	818	660	4572*

The statistic at the intersection of the "Use together nearly all the time" row and the "heavier" column is interpreted as follows: Approximately 25 percent of senior high school students who are heavier drinkers use marijuana together with alcohol nearly all the time.

[1]Table 3 reproduces table VI. 19 in the RTI final report (Rachal et al. 1980a: 120).

[2]See the technical notes for definitions of the drinking levels.

*Includes 1079 respondents who were classified as abstainers in the drinking level classification.

In 1978, an estimated 1.6 million senior high school students were heavier drinkers (Lowman 1981). About one-fourth, an estimated 400,000 students, used marijuana and alcohol together at least once a week, and as many as 3.2 million sometimes combined marijuana and alcohol use (29 percent of the 11,180,409 students in grades 10 to 12 in the spring of 1978 when the RTI survey was conducted).

Implications

The extent of marijuana use among senior high school students is widespread, and patterns of marijuana use among the Nation's senior high school students are similar to patterns of alcohol use. There is clearly a strong association between use of the two drugs.

Specific findings from the 1978 survey have several implications for policy and program planning:

Programs developed to prevent or curb alcohol problems can profitably integrate efforts to also prevent marijuana use. Alcohol and marijuana use are extensive. The patterns and correlates of their use are similar, and many students who are heavier alcohol users are also frequent marijuana users. Efforts that simultaneously address problems related to use of both drugs often can be more cost effective than independent, drug-specific efforts. See *Facts for Planning No. 3* (Lowman 1981/82b) for information on the interdependence of alcohol use and seven types of psychoactive drugs in addition to marijuana.

Prevention efforts directed to both marijuana and alcohol use need to be initiated in primary school. Although 4 times as many students first tried alcohol when they were under 12 years of age than first tried marijuana (13 percent as compared with 3 percent), the number of students exposed to use of both drugs at early ages justifies the initiation of major prevention efforts by the third grade when marijuana is first used (figure 1).

Programs designed to prevent or reduce accidents arising from driving while intoxicated should focus on problems related to intoxication with marijuana as well as with alcohol. The RTI data show that senior high school students who are heavier drinkers are also more likely to be frequent marijuana users, and are more likely to use the two drugs together. Thus, students at greatest risk for driving when intoxicated with alcohol are among those at greatest risk for driving when intoxicated with marijuana.

Marijuana, like alcohol, impairs driving ability and increasingly has been found a factor in fatalities (U.S. DHEW 1979; NIDA 1980a, 1980b). Further, research shows that combined alcohol and marijuana use can have a potentiating effect; that is, the effect is even greater than occurs in response to use of either drug alone (NIDA 1980a, 1980b). Thus, students who combine alcohol and marijuana use are even more prone to have serious driving accidents than students who use only one drug or the other.

Technical Notes

RTI Survey Methodology and Procedures

Details on RTI survey methods, sampling strategy, and sample validity are presented in the technical notes of *Facts for Planning No. 4* (page 66). As in *Facts for Planning Nos. 1, 2, and 3*, reported percentages in FFP No. 5 are based on the 1978 sample weighted to represent the sociodemographic characteristics of the total population of 10th to 12th grade students in the United States at that time.

Five percent of the students sampled in 1978 did not answer the question on recency of marijuana use. This nonresponse was considerably greater than in a comparable survey conducted by RTI in 1974 among both junior high (7th to 9th grade) and senior high (10th to 12th grade) students. It is also higher than the nonresponse rate for high school seniors reported by Johnston and associates (1979). These differences may be attributable to the question format, the method of recording answers, and the perceived confidentiality of the data, although no one explanation is completely satisfactory. However, the patterns of nonresponse in the RTI, ISR (Johnston et al. 1979), and NIDA studies (Fishburne et al. 1980) may explain apparent discrepancies in prevalence estimates among the three studies.

Prevalence and recency data from the 1978 RTI study were compared with these other two major national studies conducted at about the same time (Rachal et al. 1980a). The RTI study showed somewhat lower rates than the other two studies, both for prevalence and recency of use of most drugs. However, these differences are generally not statistically significant, and overall patterns of use are generally the same. Marijuana use by 16- to 17-year olds in the RTI and NIDA studies is essentially the same despite RTI's use of a school sample and NIDA's use of a household sample.

A comparable survey conducted by RTI in 1974 included a limited set of items on drug use. Because of the increasing interest in drug use and its relationship to alcohol use and problems, a more comprehensive assessment of drug use, especially marijuana use, was included in the 1978 RTI questionnaire. The technical notes in *Facts for Planning No. 4* (page 66) provide background information on the 1974 and 1978 survey.

Marijuana and Hashish

Marijuana and hashish are products of the plant *Cannabis sativa*, commonly known as hemp. All RTI questions on cannabis use specified marijuana *or* hashish. For example, "If you had the chance to try marijuana or hashish, would you like to do so?"

Marijuana is composed of the cut and dried leaves, tops, and stems of the hemp plant. It is generally considered lower than hashish in the percentage of delta-9 tetrahydrocannibinol (delta-9-THC), the major psychoactive ingredient in cannabis. Hashish is a concentrated product, formed from the resinous secretions of the hemp plant. Both marijuana and hashish range widely in strength. Domestic hemp is psychoactively weak, usually less than 0.5 percent of delta-9-THC (Wilford 1981) as compared with imported Colombian marijuana, confiscated samples of which averaged over 4 percent in 1979 (NIDA 1980b). The range of strength in hashish appears to be even greater, varying from trace amounts of delta-9-THC up to 10 percent (Wilford 1981).

Two factors make the social use of marijuana potentially more hazardous than

the social use of alcohol: (1) lack of knowledge about marijuana's relative purity and strength, depriving users of control over its short- and long-term effects, and (2) the fat solubility of delta-9-THC.

Marijuana of unknown origin may be laced with contaminants to increase its volume and the seller's profit, or with other psychoactive drugs to improve its effect and strength (and thus chances for future sales). Levels of delta-9-THC appear to be higher in currently available samples than was the case 5 to 10 years ago. Concentrated hashish oil, available on the street only within the last few years, ranges in delta-9-THC content from 11 to 28 percent (NIDA 1980a).

Because delta-9-THC is fat soluble, it remains only briefly in the bloodstream before it is stored in the fat cells of a number of organs, including the brain. THC has a half-life of 8 days (Wilford 1981); that is, only half of the amount stored in tissue is eliminated after 8 days. This means a single dose of marijuana is not completely eliminated from the body for over 4 weeks. This contrasts with water-soluble alcohol, eliminated within hours after consumption.

Marijuana is chemically more complex than alcohol; its metabolism is only partially understood. Delta-9-THC is only one ingredient in cannabis. The plant contains 419 individual compounds, 61 of which are cannabinoids—chemicals specific to cannabis. Thus, components in addition to the principal psychoactive ingredient may modify the drug's effects and explain the "common street belief that different types of marijuana have different effects not wholly related to their THC content" (NIDA 1980a).

Heavy, frequent marijuana use also is believed to have a greater potential for impairing the structure of brain tissue than have opium products because cannibanoids accumulate in tissue and are not readily metabolized, thus serving as a "foreign body" in the brain (Wilford 1981). For recent summaries of the effects of cannabis use on the reproductive, immune, pulmonary, cardiovascular, cerebral, and neuroregulatory systems, see NIDA (1980a, 1980b) and Wilford (1981).

Acute marijuana intoxication is known to impair skills necessary for learning such as recent memory, verbal facility, and attentiveness (NIDA 1980a, 1980b; Wilford 1981). It is believed by many clinicians that regular marijuana use in childhood and adolescence endangers learning and psychological development. Studies (Wilford 1981) have shown that long-term psychological impairment can result from chronic marijuana abuse. The psychological effects of moderate use are less clear, although psychomotor functions are definitely impaired, even at moderate social levels of use.

Definitions of Students' Drinking Levels

The RTI survey used the following definitions of drinking levels: *abstainers* don't drink, or drink less than once a year; *infrequent drinkers* drink once a month at most and drink small amounts per typical drinking occasion; *light drinkers* drink once a month at most and drink medium amounts per typical drinking occasion, or drink no more than 3 to 4 times a month and drink small amounts per typical drinking occasion; *moderate drinkers* drink at least once a week and small amounts per typical drinking occasion, or drink 3 to 4 times a month and medium amounts per typical drinking occasion, or drink no more than once a month and large amounts per typical drinking occasion; *moderate/heavier drinkers* drink at least once a week and medium amounts per typical drinking occasion, or drink 3 to 4 times a month and large amounts per typical drinking occasion; and *heavier drinkers* drink at least once a week and large amounts per typical drinking occasion. *Facts for Planning No. 2* (Lowman 1981/82a) provides more detailed definitions of these six drinking levels, and discusses the question underlying them and the procedures used to construct the drinking level classification.

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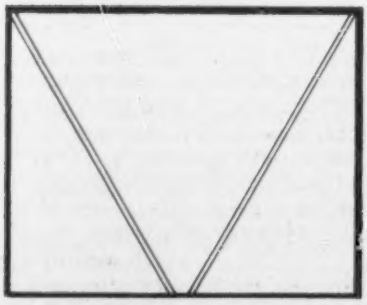
*These publications are available for purchase from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

This article was developed largely from data presented in The Extent and Nature of Adolescent Alcohol and Drug Use: the 1974 and 1978 National Sample Studies, *the final report of the Research Triangle Institute on the results of a 1978 survey of adolescent drinking practices. Robert L. Hubbard, J. Valley Rachal, and Elizabeth R. Cavanaugh were on the staff of the Research Triangle Institute and among authors of the final report. Cherry Lowman is a staff member of the National Clearinghouse for Alcohol Information, and adapted parts of the RTI final report for this article.*

LETTERS



To The Editor:

Alcohol Health and Research World is continuously a vehicle for excellent information regarding alcoholism. The publication has been of great assistance to the alcoholism field. And, it is an interesting magazine!

I do wish to express concern over what I believe is a single exception to this enviable record.

In the "Newsnotes" component of the Fall 1981 issue, there is a lengthy description of a Conference Board report entitled, "Dealing With Alcoholism in the Workplace." When this report was first published in 1980, many of us in the occupational alcoholism field were surprised and shocked at the conclusions presented in this report. Upon additional examination, we discovered the rather inadequate research which was the basis of this report. This discovery caused us to question seriously the validity of those conclusions.

In a recent *ALMACAN* (Vol. 11, Issue 8, August 1981) that research was thoroughly discredited. In that *ALMACAN* commentary, the Conference Board's report was described as having ". . .such poor quality research that the findings must be dismissed as invalid and ultimately meaningless. . . ."

My point in writing to you about this matter is to indicate that, *in my opinion*, those shortcomings should have been included in the "Newsnotes" section's description of the report. I believe the occupational program people and/or the new Editorial Advisory Board associated with *Alcohol Health and Research World* would tend to support this opinion. Such warning flags would have probably meant the inclusion of significantly stronger disclaiming information regarding this report in the "Newsnotes" section.

Again, we very much appreciate and enjoy *Alcohol Health and Research World*, but thought we ought to express some concern regarding the matter described above.

G.R. Stanford
Executive Director
Workers Assistance Program of Texas
Austin, Texas

To The Editor:

This letter is to protest as vigorously as I can the review in your Fall 1981 issue (on pages 41-42) of a report put out by the Industrial Conference Board entitled "Dealing With Alcoholism in the Workplace."

To my knowledge practically all respected research people in this field have deplored the sloppy and incompetent methods that characterized this study.

It was not too long ago that I wrote an invited piece for your Journal entitled "Applied Research Studies: Job Based Alcoholism and Employee Assistance Programs" in which I observed, in the second paragraph, "Unfortunately many of these (studies) fail to adhere to basic requirements for sound research such as access into and rapport with samples from workplaces (both management and union), sound statistical and field methods, and good data analysis techniques."

Recently the official publication of the Association of Labor Management Administrators and Consultants on Alcoholism (The ALMACAN) printed a rather detailed analysis of the many flaws in the Conference Board study. What we desperately need are good, sound replications of current studies to nail down basic points. Unfortunately this study, as reported, fails to meet many of the basic requirements of good research, and so fails to add to our accumulated knowledge.

I much deplore your favorable review and earnestly request that you publish this letter as a reaction to it.

Harrison M. Trice
Professor
New York State School of Industrial and Labor Relations
Cornell University
Ithaca, New York

To The Editor:

I think you should be aware of professional criticism of the Conference Board Report *Alcoholism in the Workplace*. The article in Newsnotes in the Fall issue presented the research as if it were undisputed and acceptable to the research community. The fact is that the Research Committee of ALMACA was quite critical of the research procedures and conclusions. The committee cautioned program administrators and consultants against applying any of the report's conclusions to their own work.

Walter Reichman, Ed.D.
Chairman, Research Committee
ALMACA

The Editor Replies: The ALMACAN *article criticizing the Conference Board Report was published after the Fall issue of* AH-RW went to press. The article is summarized in the Newsnotes section of this magazine issue.

RESEARCH REPORTS

Women at Higher Risk Than Men For Development of Liver Disease

Women tend to develop alcoholic liver disease more readily than men and should drink considerably less than men to avoid development of such diseases say J.B. Saunders, M.B., and associate of King's College Hospital and Medical School in London, England, in a recent review of published studies appearing in the *British Medical Journal* (Vol. 282; April 4, 1981; pp. 1140-1143).

Twenty years ago, alcoholic cirrhosis was a disease primarily affecting middle-aged and elderly men, the investigators say. Men outnumbered women by a nearly 5 to 1 ratio. In the past 10 years, however, the ratio has become 2 to 1. Four times as many women with alcoholic cirrhosis were hospitalized in 1977 as in 1970.

"The increased frequency of alcoholic liver disease among women is not surprising," the authors say, in light of increased alcohol consumption among women. "But the extent of the increase over the past 10 years is far greater than one would predict from the change in frequency of other alcohol-related problems." Noting that "5 to 10 times as many men as women are problem drinkers, in contrast to the 2 to 1 ratio for those with liver disease," the authors suggest that "women may develop alcohol-induced liver damage when consuming smaller quantities of alcohol than men."

The investigators found that most past studies supported this observation. One early Boston study showed liver disease occurred in 14 of 20 female alcoholics (70 percent) studied, compared with 41.2 percent of male alcoholics studied. A more recent study found that the most severe form of alcoholic hepatitis occurred in 11.5 percent of the women, but in only 3.3 percent of the men studied.

The studies suggest that women tend to drink less and for a shorter period of time than men before liver disease occurs. One study showed risk began to increase gradually for women drinking more than 20 grams of alcohol (approximately two drinks) daily and for men drinking more than 60 grams daily. The greatest risk was among women drinking more than 40 grams daily and men drinking more than 80 grams daily.

To avoid the specific risk of alcoholic liver disease, the researchers say, women who choose to drink should drink less than 40 grams of alcohol daily and men should drink less than 80 grams daily.

Susceptibility differs greatly between the sexes, the investigators say. "The risk of cirrhosis for women drinking 60 to 80 grams of alcohol a day was at least 35 times greater than that for men," they say.

Most recent studies showed no significant difference in long-term survival between the two sexes. In one study of 278 patients with alcoholic liver disease 59 percent of the women and 66 percent of the men who abstained after diagnosis survived 5 years. In the group that continued to drink, 5-year survival rates were 38 percent for women and 43 percent for men.

Why a woman can drink only about half as much as a man and still develop cirrhosis remains a puzzle. The investigators speculate that differences in body composition may be partially responsible. Women have relatively more fatty tissue than men (33 percent as opposed to 21 percent), which, because of its poor blood supply, takes up alcohol less readily. "Hence, even if dose is adjusted for body weight, this results in higher blood concentrations in women than men and may be expected to cause more liver damage," they say.

They also note that women are more likely than men to develop autoimmune disorders such as rheumatoid arthritis in which the body is attacked by its own natural defenses against infection. "Because of their greater propensity for autoimmune reactions, female drinkers may be more likely to develop alcoholic hepatitis and by so doing progress to cirrhosis more rapidly than men," they say.

Women should be included in screening programs that, until now, have focused on men, the researchers say. Doctors must be more alert to possible liver damage in women with nonspecific abdominal symptoms and should make greater use of screening tests designed to detect high alcohol intake. Finally, the researchers say, educational programs are needed to increase awareness among women of hazardous drinking levels.

For more information, contact J.B. Saunders, M.B., M.R.C.P., King's College Hospital and Medical School, London, England, SE5 9RS.

—Nancy Johnson, Staff Writer

RESEARCH REPORTS

Medical, Social Service Students Not Motivated To Work With Alcoholics

Future medical and social service professionals may lack motivation to devote professional time to problem drinkers, expressing pessimism about problem drinkers' ability to overcome their problems, according to researchers at The Medical Foundation, Inc., a Boston-based health research and education organization. Foundation researchers, Henry Wechsler, Ph.D., and Mary Rohman, M.A., conducted a mail survey of 1,106 graduate students as part of an NIAAA-funded study to gauge future caregivers' expectations and attitudes regarding the treatment of people with alcohol-related problems. The graduate students were enrolled in schools of nursing, medicine, and social work as well as in counseling programs in seven major universities in or near the Greater Boston area.

Respondents were questioned about their exposure to alcohol education, their reactions to the disease concept of alcoholism, and their willingness to treat people with alcohol-related problems. In addition, the survey asked the students to rate different types of treatment on the basis of therapeutic effectiveness and to indicate how likely they thought recovery was for most alcoholics.

Approximately one of three students (34 percent) said they felt that few people are able to overcome drinking problems, "even with treatment." Some two-thirds (63 percent) foresaw eventual relapse for alcoholics who achieve sobriety, and about one-half (51 percent) expressed the opinion that alcoholics are seldom able to follow through with treatment plans. In addition, the future caregivers said they did not consider any form of treatment to be a "very good" therapeutic resource for alcoholics; the treatment source most often rated "very good" by the students (73 percent) was Alcoholics Anonymous (AA)—an organization that does not directly involve caregivers in its work.

The study's findings are "discouraging," the researchers say, because of what they suggest about the current state of caregiver training. According to the authors, "The findings raise serious questions about the way in which professional programs are preparing students to deal with alcohol abuse problems." Although most of the respondents said they had been exposed to some type of alcohol education and indicated they agreed with the disease concept of alcoholism, the survey showed that students doubted alcoholics' ability to recover and are reluctant to treat them, the authors said. "Professionals are understandably reluctant to treat clients whose chances for recovery are poor or if they think their skills will not be effective. In other words, if a professional thinks that a problem cannot be solved or that a client cannot be helped, the chances are poor that he or she will respond effectively, if at all, to that client."

Wechsler and Rohman also noted that "a disproportionate number of problem drinkers among help-seekers has been noted at many health and social service agencies. This is because problem drinkers tend to experience medical, psychosocial, and family problems more frequently than nondrinkers or 'normal' drinkers and also because they may seek to avoid that 'alcoholic' label connected with receiving treatment from alcoholism agencies," they said.

However, the authors said, much can be done by professional schools to improve the future responses to problem drinkers. Many resources exist for treating alcohol-related problems, he said, but they need to be carefully evaluated. "Questions of program effectiveness, including what is effective for people with special needs, must be addressed in professional education programs so that the future professionals will have confidence in their professional skills.

"Professional self-confidence and familiarity with alternative resources can serve to generate a more optimistic prognosis for alcoholics, a more positive attitude toward alcoholics as clients, and improvement in the preventive as well as therapeutic impact of future caregivers," they said.

For more information, contact Henry Wechsler, Ph.D., The Medical Foundation, Inc., 29 Commonwealth Ave., Boston, MA 02116.

—Jill Vejnoska, Staff Writer

BOOK REVIEWS

Beyond Alcoholism by Dan Beauchamp. Philadelphia. Temple University Press, 1980 (222 pp.; $17.50).

The 1970s brought significant new directions in the conceptualization and development of alcohol policy, both at the national and international levels. Indeed, the term alcohol policy can be considered largely a product of these new trends, emphasizing the importance of areas of concern beyond those related to alcoholism treatment in developing responses to alcohol problems. Much research has come from abroad--notably Finland, Canada, and, most recently, the World Health Organization—but there has also been an impact in the United States. NIAAA's short-lived focus on stabilizing consumption and its active role in the debate concerning health warning labels are perhaps the most notable examples of the agency's attempt to formulate and advocate an alcohol policy dealing with issues beyond those related to alcoholism treatment.

Dan Beauchamp's recent book *Beyond Alcoholism* provides an excellent and timely history and analysis of these recent winds of change. In a lucid, well-documented, and concise narrative, Beauchamp discusses the history of the disease concept of alcoholism and its limitations in explaining drinking patterns and problems within our society; he advocates the importance of focusing attention on alcohol problems and alcohol as a consumer commodity; and he makes specific policy recommendations. Along the way, he digresses to critique the concept of the "hidden alcoholic," particularly as conceptualized by AA, and provides a case study illustrating recent developments in alcohol policy in Finland.

Beyond Alcoholism is most valuable as an introduction and background to the policy debates that are now occurring and are almost certain to intensify in the coming decade. Beauchamp explains and synthesizes diverse bodies of literature, making them easily understandable and more available to those not conversant with the research that has led to the policy debates. The various critiques of the disease concept are well presented, and a very convincing case is made both from an historical and analytical point of view—for moving beyond its limiting focus. *Beyond Alcoholism* can be regarded as an advocacy piece, urging new directions in alcohol policy based on the research that is summarized.

Beauchamp's discussions of the "alcohol alibi" and the "myth of social drinking" (chapters 2 and 4) are particularly well documented and concise. Relying on general population studies, he argues that drinking practices do not break down into two distinct categories—alcoholic drinking and social drinking—but rather reflect a wide range of uses and problems among diverse populations. In fact, the population of "problem drinkers" is not constant; rather, people (particularly young men) "travel through" the problem population, reporting problems at one time but not necessarily at another.

Having made the case for an expansion of the alcohol policy debate beyond individual treatment strategies, Beauchamp then provides a good explanation of the "per capita consumption thesis"—the research (conducted mostly by Nordic and Canadian scholars) that purports to demonstrate that a society's level of consumption is directly related to the incidence of alcohol-related problems. He also goes beyond this relatively narrow research focus, providing a broader justification for placing restrictions on alcohol availability generally. Summarizing (perhaps too briefly) his work on public health as social justice, Beauchamp argues from a public health perspective that the primary responsibility for seeking policy alternatives that will limit the incidence of alcohol problems, including alcoholism, rests at the community level. He states that "the absence of alcohol problems is never a purely personal accomplishment, but is a direct consequence of social as well as individual factors." The tendency to "blame the victim," in this case the alcoholic, must be reversed in order to define and articulate this community responsibility.

This argument is central to Beauchamp's primary criticism of the alcoholism movement. Redefining alcoholism as a disease (rather than a moral weakness) does not remove the stigma or blame from the alcoholic. It still absolves the society, community, and other individuals from the need or obligation for positive action. Whether alcohol problems are viewed as a disease or as a moral weakness, the responsibility remains solely with the individual, without regard to the environment that contributes to alcohol abuse and problems. The crucial issues concerning availability, control policies, and public attitudes toward consumption are thus ignored under either conceptualization. Beauchamp's discussion of Alcoholics Anonymous, based on original research, is particularly interesting within this context.

Beauchamp views the conflict between "moral" and "medical" explanations of alcohol problems as a clash between the "cultural fundamentalism" prevalent during Prohibition, which views alcohol problems as a failure of will, and "modernism," which attributes alcohol problems to a lack of capacity on the part of the alcoholic. In either case, the individual remains the focus. He argues that the recent ecology and consumer protection movements are examples of a "post-modern" movement that is challenging the value of unbridled individual consumption, and suggests that the new alcohol policy debates may be one aspect of this "post-modernism."

Having defined the new arena for policy debate, Beauchamp in the last chapter makes specific policy recommendations, including limiting per capita consumption; sharply increasing alcohol taxation; paying increased attention to alcohol control laws, particularly drinking age laws; considering increased alcohol advertising restrictions; requiring mandatory use of airbags and passive restraints in automobiles; paying increased attention to the consequences of teenage drinking; and encouraging community participation in alcohol problem prevention activities.

Beauchamp has difficulty in addressing the complex issues that his policy proposals entail. The central problem with his analysis lies, I believe, in its failure to address critically the cultural, political, and economic factors that define alcohol use and abuse in our society. Alcohol problems, for example, are most prevalent among lower income groups, and Beauchamp's own analysis suggests that environmental factors such as poverty may influence the development of alcohol problems. Prevention strategies, then, may need to address broad social issues beyond alcohol-specific policies and automobile airbags—the only recommendation he makes that is not alcohol specific. It is also important to recognize that cultural and environmental issues may significantly limit the potential value of the alcohol-specific recommendations made. Indeed, Beauchamp's proposals appear rather limited and modest, given his sweeping analysis of the shortcoming of disease-concept policies. The public health approach to alcohol problems lends itself to a more promising vision.

The policy proposals present other difficulties as well. Beauchamp's suggestion that a "post-modern" period may be occurring raises questions: How can alcohol policy initiatives be allied with other issues he identifies as focal points for this movement? Why has the consumer protection movement, for example, ignored

alcohol-related issues (other than opposing price fixing, which Beauchamp would argue actually exacerbates alcohol problems)? There is little discussion of how to build community and popular support for his proposals. This may be a crucial issue, since there is little evidence that the public would accept, let alone advocate, stricter availability restrictions and higher prices. Finally, Beauchamp's presentation of recommendations does not adequately explore the serious adverse consequences that may result. Large increases in alcohol taxes may create a viable bootleg trade, for example, and strict minimum drinking age laws may also create social and legal problems.

These criticisms, however, are minor points and perhaps they reflect merely a desire for more than was promised by this volume. Beauchamp sets out to raise issues and to justify new policy directions, tasks that are accomplished with style. The analysis is provocative and is certain to contribute to the quality of future policy discussions. *Beyond Alcoholism*, in short, is essential basic reading for those participating in the alcohol policy debates of the coming decade.

James F. Mosher
Alcohol Research Group
Berkeley, California

Biochemistry and Pharmacology of Ethanol, edited by Edward Majchrowicz and Ernest P. Noble. New York: Plenum Press, 1979 (Vol. I, 704 pp., $47.50); (Vol. II, 572 pp., $42.50).

Today is well established that alcohol abuse and alcoholism represents a major health, economic and social issue. Alcohol problems in the United States afflict over 10 million people and approximately 200,000 individuals die prematurely each year from a variety of ethanol-related pathologies and factors, including cirrhosis, cancer, heart disease, suicide, homicide, highway fatalities and other accidents.

Alcoholism, the third leading cause of fatalities in the United States, can be controlled and treated. Without question, the economics alone provide enough impetus for an investment and commitment by our nation and other World governments to wage war against this disease.

Fundamental to our understanding of alcohol-related problems is knowledge acquired through painstaking laborious research by dedicated scientists. Significant research advances in alcoholism, both basic and clinical, are beginning to build a rational framework necessary to understand, prevent, and treat alcoholism. The explosion of alcohol-related research over the past decade is quite remarkable in light of the fact that the Federal expenditure has been relatively small.

Alcohol, the simple chemical, is so complex in terms of its biological interactions, that no single individual or small group is capable of providing a meaningful analysis of the field. Consequently, two internationally respected and dedicated alcohologists, Drs. Edward Majchrowicz and Ernest P. Noble, called on a large number of experts in assembling the most complete reference book to date on the biochemistry and pharmacology of ethanol. This two volume treatise provides a detailed, but concise and critical review of the biochemistry and pharmacology of ethanol. The important information is delivered by highly qualified experts writing authoritatively. The editorial objective of these volumes was to nurture the growing quality of alcohol research and to foster growth interdisciplinary involvement in alcohol research. The editors encouraged the authors to draw their own conclusions, to expand on their own theories and hypotheses, and to restrict citations to only published data. In addition, each chapter was referred by at least two experts in the field and revised accordingly prior to publication; not all submissions met the stringent criteria.

Each volume is divided into thirteen sections, arranged in logical sequence and progresses from the action of ethanol at the molecular level to its effects at higher levels of biological organization. This reference book begins with coverage of ethanol absorption and distribution in the body, then delineates enzymatic mechanisms of ethanol elimination and examines the effects of ethanol of the intermediary metabolism and various tissues and body organs. Pathological changes accompanying acute and chronic administration of ethanol and the interactions of ethanol with drugs, neurotransmitters, and hormones are also discussed. It concludes with chapters on animal models, behavioral aspects of alcohol intoxication and addiction, chromosomal damage and the chemotherapy of alcoholism. The book is well indexed and this provides a most useful addition to this exhaustive work.

Certain newer aspects of alcohol research—such as the role of neuropeptides and amine-aldehyde condensation products in tolerance, dependence and preference; receptor-membrane coupling interactions; and central and peripheral pathologies—were not adequately covered, however, the book is still the best reference source on the subject that I know.

The subject matter is of both theoretical and practical importance, and should serve as an excellent reference source for pharmacologists, biochemists, clinicians and other scientists interested in the biological and chemical mechanisms in response to alcohol. Although certain aspects of this work will become historical in nature, for the most part, it will serve as a reference source for many years to come.

The editors and contributors of the *Biochemistry and Pharmacology of Ethanol* should be congratulated in producing a landmark account on the subject. At a recent opening of an alcohol treatment center in San Antonio, Texas, the famous movie star and recovering alcoholic, Gale Storm discussed her new book, *I Ain't Down Yet*, reminiscent of her leading roles in "The Unsinkable Molly Brown". As suggested by the title of her book, Storm affirms that there is hope for the alcoholic. If we accept the fact that alcoholism is a biological disorder influenced by environment, then we must recognize the importance of, and continue to encourage, research into its multifaceted biological actions. The editors and authors of this volume have made a substantial contribution toward reduction and eventual eradication of alcohol problems.

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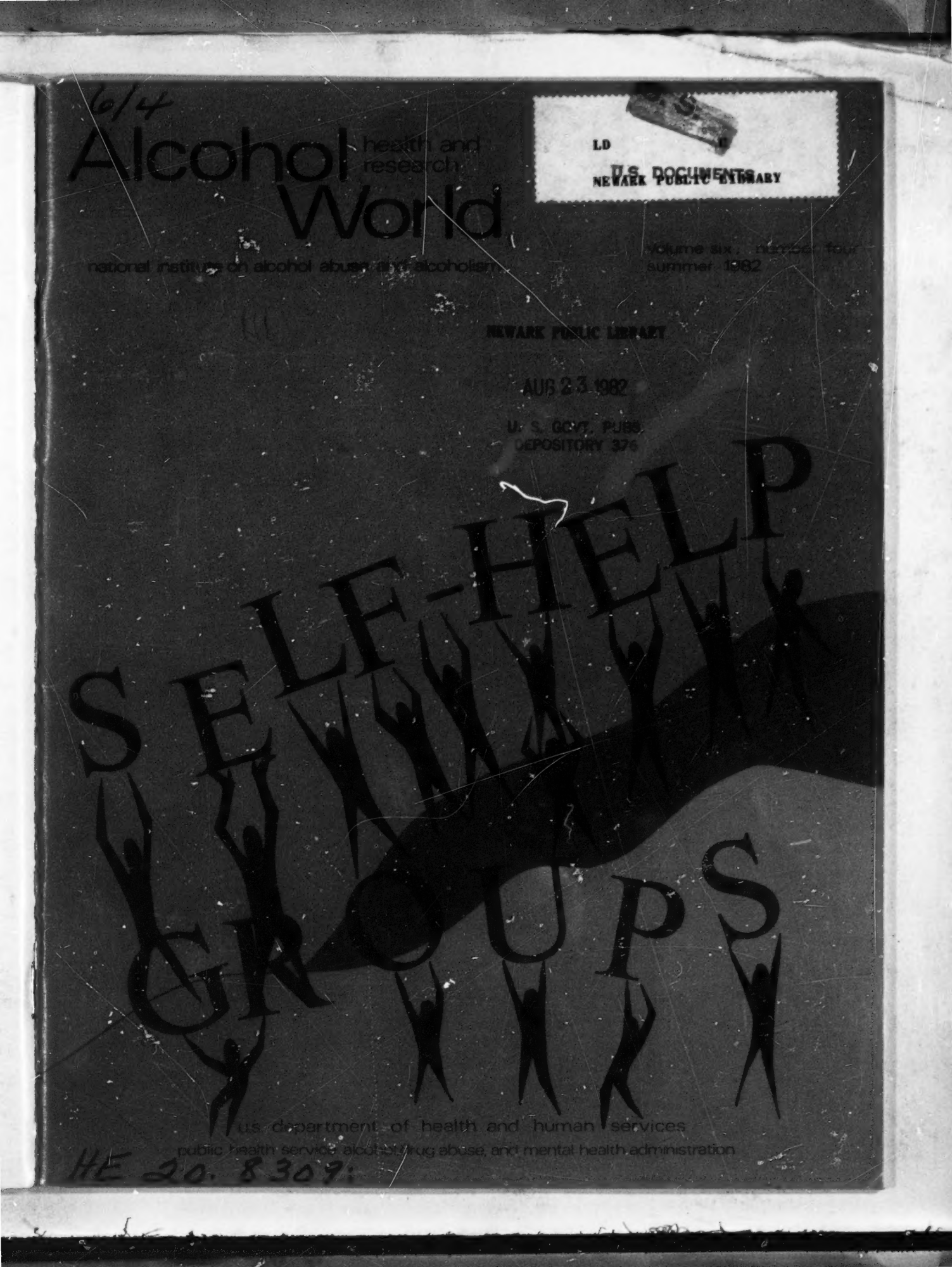

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FROM THE EDITOR

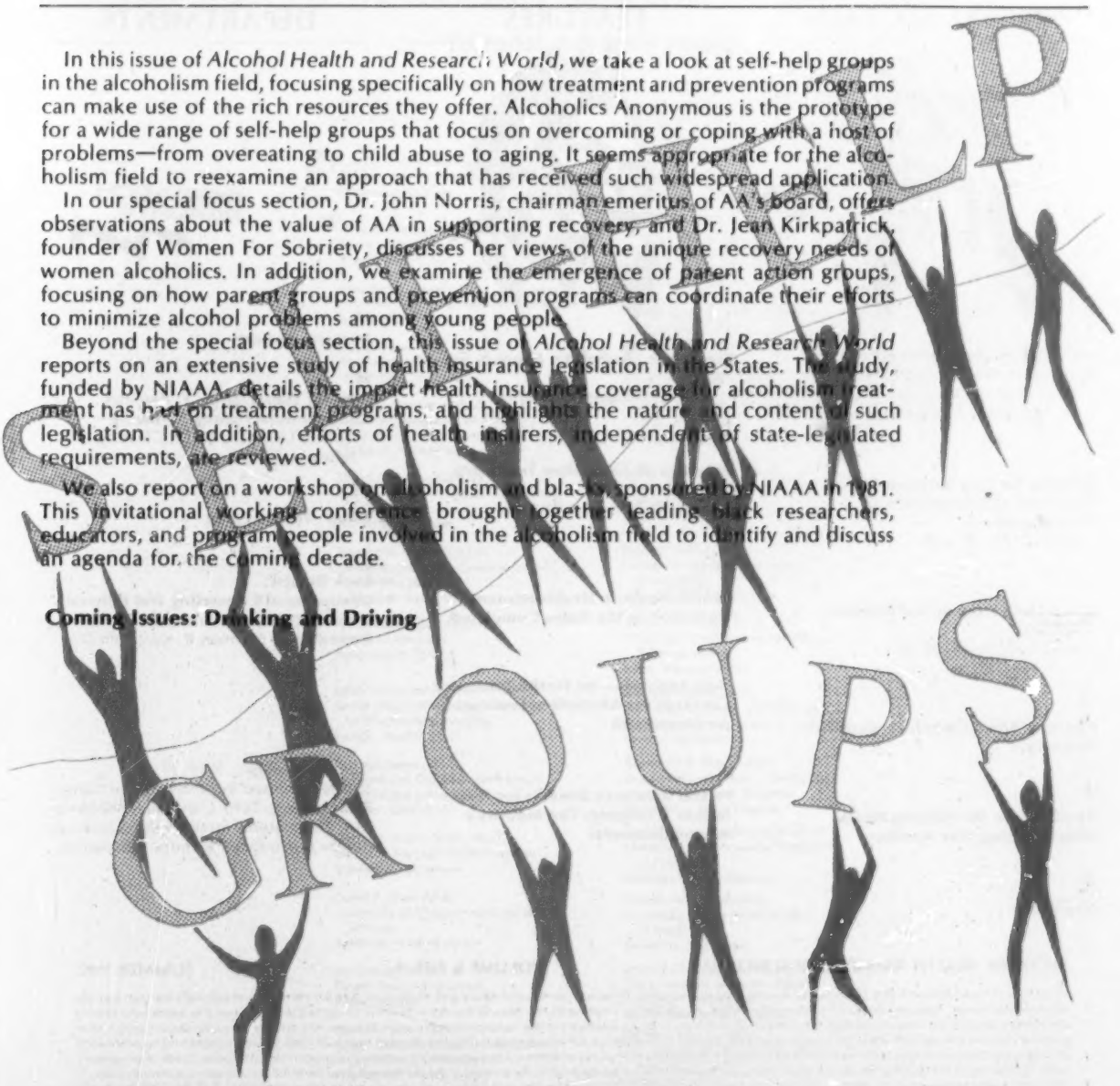
In this issue of *Alcohol Health and Research World*, we take a look at self-help groups in the alcoholism field, focusing specifically on how treatment and prevention programs can make use of the rich resources they offer. Alcoholics Anonymous is the prototype for a wide range of self-help groups that focus on overcoming or coping with a host of problems—from overeating to child abuse to aging. It seems appropriate for the alcoholism field to reexamine an approach that has received such widespread application.

In our special focus section, Dr. John Norris, chairman emeritus of AA's board, offers observations about the value of AA in supporting recovery, and Dr. Jean Kirkpatrick, founder of Women For Sobriety, discusses her views of the unique recovery needs of women alcoholics. In addition, we examine the emergence of parent action groups, focusing on how parent groups and prevention programs can coordinate their efforts to minimize alcohol problems among young people.

Beyond the special focus section, this issue of *Alcohol Health and Research World* reports on an extensive study of health insurance legislation in the States. The study, funded by NIAAA, details the impact health insurance coverage for alcoholism treatment has had on treatment programs, and highlights the nature and content of such legislation. In addition, efforts of health insurers, independent of state-legislated requirements, are reviewed.

We also report on a workshop on alcoholism and blacks, sponsored by NIAAA in 1981. This invitational working conference brought together leading black researchers, educators, and program people involved in the alcoholism field to identify and discuss an agenda for the coming decade.

Coming Issues: Drinking and Driving



Perspectives

An AH&RW interview feature

The interface between treatment programs and self-help groups was the focus of the following interviews, conducted by *Alcohol Health and Research World* staff writers John Small and Nancy Johnson.

Lee Grutchfield, Ph.D., is a clinical counselor in private practice at the Eastwood Counseling Clinic in Tallahassee, Florida. A long-time specialist in alcoholism treatment, he is past president of the Panhandle Alcoholism Council in Panama City (FL) and was on the Board of Directors of the Pikes Peak Council on Alcoholism in Colorado Springs, Colorado.

Q. Is it appropriate to get alcoholic clients—while they are in treatment—involved in AA or other self-help groups?

A. I think it is not only desirable, but it's *essential* for lasting recovery. To not expose clients in treatment to the program that works the best for the most is to deny them an educated view of the rewards of recovery. AA is the place where one meets and talks with well alcoholics. More often than not, it's the well alcoholics who teach the sick ones how to cope with the day-to-day problems of sober living after formal treatment ends. I've heard many people in AA say, "I need less help with my drinking problem than I do with my problems of daily living." AA and some of the newer peer therapy groups, such as Women For Sobriety, provide ongoing support and a loving structure

Continued on page 4

A staff member at the General Service Office of Alcoholics Anonymous (AA), who is serving in a cooperative assignment with the professional community, was also interviewed.

Q. When is it most appropriate to involve an alcoholic in AA or other self-help groups?

A. AA is always available to the alcoholic who wants it and AA will cooperate with any treatment facility. We can bring meetings into the facility for those patients unable to go out. There are some facilities that allow their patients to go out in the community to attend meetings and sometimes AA members will help facilitate this.

AA members will also cooperate in helping ease the transition from treatment into the AA community. One thing being done in some areas is the use of an interim sponsor. Sometimes a treatment center may use ex-patients who are now active in AA; other times, members from the community who wish to be of service in this way will let the center know they are available to assist soon-to-be-discharged patients.

Sometimes, having AA literature available for patients while they're in treatment can help dispel some of the feelings they might have about AA. But I really believe it's the personal contact between the patient and a member of AA that can be the key to acceptance of the help AA can offer. Many times, I think people are hesitant

Continued on page 5

Samuel Wenger, Ph.D., is education director for Saint Anthony Hospital's Department of Talbot Hall, an alcoholism treatment center in Columbus, Ohio.

Q. If a client does not want self-help group involvement, how can treatment programs help bridge the gap between the treatment program and a return to the community?

A. Treatment programs can certainly bridge the gap. If the patient is referred to a treatment agency by an employer, the treatment agency can communicate with the referral source and make it clear that the patient will be expected to participate in a self-help group regularly. By utilizing clout—threat of losing a job or not being able to remain in school—referral sources can buttress the treatment agency's work. We are as effective with patients who are forced into treatment as we are with the rare persons who by their own accord decide that they need treatment. A referral source who uses clout is an important determinant of the successful patient. Participation in Alcoholics Anonymous or Narcotics Anonymous is a realistic demand. Corporations know this; public schools are learning. Employers need to remember that alcoholism is a primary illness and a fatal one, and that without some form of accountability, the patient is going to die. By using clout we will see increasing numbers of persons recover from the disease.

Continued on page 24

Perspectives *Grutchfield*
From page 3

within which one can get help with the problems of life and therefore sustain sobriety. Without question, involvement in such groups increases the alcoholic's chance for lasting sobriety.

However, before we can knowledgeably and appropriately get our clients involved in AA, we, the therapists, must get involved with the fellowship. We can become involved in such ways as attending several open meetings of each group in our community; establishing a network of acquaintances with well alcoholics that we meet through attendance at open meetings—since most of us will only know sick alcoholics without such a network, and that breeds cynicism, pessimism, and burnout in our ability to help sufferers; openly verbalizing our respect and admiration for the service performed by AA members in our community; always having a current list of AA phone numbers and meeting places in the community; studying and understanding the principles of recovery so clearly described in the AA "Big Book," and having the openness to practice these principles in all *our* affairs; and understanding that we are in partnership with AA in the sense that we have the same goal—recovery for the suffering alcoholic—and our roles are complementary, not competitive, in nature.

Only when we, the therapists, are knowledgeably involved with AA or other self-help groups can we facilitate appropriate involvement for our clients.

Q. Is there a particular type of person that most benefits from self-help group involvement? Are there differences between men and women regarding the effectiveness of self-help?

A. I'm interpreting "self-help groups" to mean AA, since in most communities AA is all that's available or it serves as the model for other groups. Regarding the type of person who benefits, there may be some *internal* consistencies, but I don't think there are surface characteristics a therapist can readily identify. Those external qualities we see are the clients' means of protecting themselves and feeling significant, but they give little clue as to how much or how little they'll benefit from AA's peer therapy. My experience has been that some of the toughest, most resistant, most alienated clients—those I have least expected to identify with AA—have done so and benefited quickly and greatly. On the other hand, some who seem adaptive and compliant reject the tenets of AA and manipulate themselves out of any possible help they might get. The message in that experience is that it's *very* important not to stereotype clients and let those stereotypes dictate who we do and do not encourage to use AA. All alcoholic clients should have the opportunity to benefit from AA, or any other available self-help group—such as Women For Sobriety. The ingredients for lasting recovery from alcoholism are there.

I think the internal dynamics of both the disease and recovery process are the same in men and women. However, before a group can help stimulate the recovery process, the client must be able to identify with the others in the group and feel reasonably comfortable. AA members often recognize this intuitively, and try to meet the need by forming special groups such as young peoples' groups, womens' groups, or nonsmoking groups. Whenever there's an "in" faction that predominates in a group, those who are "out" are unlikely to benefit much or participate for very long. Ideally, both formal treatment programs and AA groups will be microcosmic cross-sections of the real world and also provide opportunities for special subgroups to meet regularly. For example, it's desirable to have access to same-sex groups to deal with such issues as sex roles. It's un-

"My experience has been that some of the toughest, most resistant, most alienated clients—those I have least expected to identify with AA—have done so and benefited quickly and greatly."

—Grutchfield

realistic to think that a group with 2 women and 23 men will be optimally helpful to those women.

Q. If a client does not want AA or other self-help group involvement, are there ways that treatment programs can help bridge the gap between treatment and a return to the community?

A. The clients we all enjoy working with are those that go to AA and love it, identify with it, and get beneficially involved from the outset. But they are also a minority. There are many more clients who won't go at all, and there are some who will attend a few meetings and "discover" why AA is not for them.

I think therapists can help bridge the gap by, first and most importantly, letting the client know we will *never* give up on them or their recovery effort. Alcoholics have a well-developed skill for facilitating rejection from the people around them. They *will* test their relationship with the therapist. So, first we establish that we are not going to reject them or give up on them. Second, we can establish continuing group counseling for program graduates to utilize. Ideally these follow-on groups will take on the air of a *generic brand* of AA fellowship. If AA is the "name brand," therapy groups can incorporate the same ingredients to some degree. Again, for this to happen, the group must be run by those who have what I call an "AA Consciousness."

We can also help our clients examine their current living dynamics and behavioral systems. The bottom line in evaluating what they're doing is, "Does it help?" In staying involved, we can teach alcoholics that alcoholism has as much to do with their ways of *thinking* as it does with their drinking. We can aid in the development of more positive, goal-oriented thought patterns. If they will abstain from drinking, we can work on the alcoholic thinking.

We can unequivocally let them know that abstinence is an absolute prerequisite for recovery. It *does not* represent recovery, but it is absolutely essential if recovery is to progress. If the clients will not abstain, we need to let them know that—while significant progress is not likely to occur—the therapist will not give up by terminating contact. Neither will we function as "enablers" by standing in the way of a developing crisis. It's always important to involve the spouse in the therapeutic efforts. A follow-on group for spouses is desirable. As soon as I come in contact with the spouse of a drinking alcoholic, I provide him or her with a copy of the excellent paperback book by Toby Rice Drews, *Getting Them Sober*. This book can be an excellent vehicle for discussion in a spouses' groups.

So, we send the message to the alcoholic that "I will always be available to you to help arrest your alcoholism." We maintain nonjudgmental contact. We allow testing to occur and we do not reject the alcoholic—ever. When the price is too high, and the pain is too bad the alcoholic will come to recognize he or she is indeed powerless over alcohol and his or her life is unmanageable. And that, after all, is the first step. □

Perspectives *AA Member*

From page 3

about going to AA because they don't know anything about it. I was certainly a good example. Before I was discharged from treatment, I received a phone call from a member of an AA group in my neighborhood, giving me her name and phone number, and asking me when I would be discharged. She said she would call me when I got home and take me to a meeting that night. And she did. Also when I arrived home, I found that the Intergroup Office had sent me a meeting book for the area, along with several AA pamphlets.

Q. Is there a particular type of person that is most likely to benefit from involvement in a self-help group?

A. Again, there's no definitive answer, but I can give you some statistics from our last membership survey. We do a random survey of our membership every 3 years. The 1980 figures showed that one out of every three at a typical AA meeting is a woman. We also found that the respondents who filled out our survey fell into several occupational categories: 19 percent of men were in sales and business and 11 percent of women; 17 percent of men and 18 percent of women were professional people; and 30 percent of men and 7 percent of women were laborers. However, AA is made up of all types of people, young people, men, women, and—more and more today—older people (50 and over) are coming in. I think this might have to do with the advent of senior citizens communities and nurs-

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Bridging The Gap Between Active Treatment And Normal Living-A A Involvement

By John L. Norris, M.D.

Stressful situations are a part of life. An individual's pattern—developed over some years—of meeting these situations and the accompanying feelings by using alcohol or other drugs will probably not be changed by a brief period of therapy. Support and education may be necessary for many months or years, perhaps for the rest of the patient's life. And professional treatment for the duration of life is not feasible, and only occasionally is it necessary or advisable. Alcoholics Anonymous (AA) is available, it costs nothing, and it is effective in a high percentage of cases where the introduction is done well. For example, nearly 25,000 responses to AA's 1980 survey of its members yielded these results: About half of those who come to AA drop out after the first 90 days; slightly more than 50 percent of those who continue to attend meetings after 90 days will remain active in AA and stay dry for at least another year; 85 percent of those who remain active for a year will continue active and sober for another 5 years; and 92 percent of those who are active and sober at the end of 5 years will probably continue their activity and sobriety indefinitely. (These statistics are based on a sample of AA members attending a meeting in a single week; the sample is estimated to be about 3 percent of the total AA membership.)

Al-Anon and Alateen are similarly available and effective. The introduction to these groups can best be made during active treatment. If AA and Al-Anon are to be part of the treatment program, and they must be, the professional staff must know the AA program and be enthusiastic about it. The most effective way for treatment professionals to develop an understanding of AA is for them to go to AA meetings

and acquaint themselves with several AA members. Any member's ideas are limited to his or her personal experience, so they should not limit themselves to knowing only one member; that one person may not "jibe" with the professional and he or she definitely will not have the whole story. In addition, treatment professionals should have the books and pamphlets of both AA and Al-Anon at their fingertips. By doing all this, they can get the "feel" of the program.

Why is it essential that treatment professionals understand and be willing to work with AA? To better understand the nature of the illness and to learn how to deal with it. Physicians and most others in the caring professions assume that patients or clients will accept their advice. We have helped them to feel better. In the case of most alcoholics, they came into treatment sick and miserable. They are leaving active treatment feeling much better physically and perhaps emotionally. We have told them that, in our opinion, their use of and dependence on alcohol or other mood-changing drugs have caused them physical, emotional, and spiritual pain, and that to stay well they must control or eliminate their use of these drugs. Yet, so often they don't accept our diagnosis and advice. Why is this so? Patients with other problems usually follow the prescribed treatment and stay out of serious trouble once they have recovered from acute difficulty. Why, then, are alcoholics and other addicts different? Why do we so often fail at assuring long-term recovery?

As treatment professionals, we may make too many assumptions about our alcoholic clients. For example, we must not assume that, since individuals are under active treatment, they want to recover from their alcoholism or other drug addiction. They want relief from their present misery, but once that is over, they are probably in the phase of compliance, which Dr. Harry Tiebout pointed out to us years ago. They have not accepted at depth the fact that the drug—alcohol or other chemical—is their most important problem at present. Other realities of which we should be aware are:

- The family is probably in as great a need of help as the problem member. Al-Anon and Alateen are helpful effective resources.
- Society's gut-level opinion is that nice people, especially nice women, cannot be drunks. It is unthinkable that a daughter or wife or favorite son or successful father could be an alcoholic. We in the helping professions may hold these same opinions.
- Many treatment professionals relax and let go of their clients too soon. Results of the recent survey of AA membership show that professionals in therapy should keep up their active interest in the patients and encourage them to remain in constant contact with AA, especially during the first 3 months.
- Denial—rejection of the idea that the drug is causing the problems—is *part* of the disease, and it is supported and strengthened by a system of rationalizations. These alibis or excuses have been rehearsed so much that the patients almost believe them. As they tell these stories to those of us who are trying to help, they are convincing, and unless we know that the stories do not fit the facts, we too believe them. One employer said to me, "Unless you have the facts so firmly documented that you can't be persuaded otherwise, these people will have you apologizing for misjudging them."
- After leaving treatment, some patients fail to accept at depth the idea that addiction to alcohol or another drug was the problem. As they remember it, the drug provided quick comfort in many stressful personal situations, and in the beginning, no serious problems directly related to use of the drug emerged. As problems developed during or after drinking episodes, it was easy to blame something else—to deny that the drug was causing the problem. Eventually, however, stressful situations will return, as will desire for the quick relief that alcohol once provided. Unless the addicts themselves have changed, or their *situations* have changed, they will not be able to resist the urge to turn again to their chemical comforter, even though they know that worse trouble usually follows.
- Alcoholic people have rejected themselves as persons; they feel unworthy of care, compassion, or love. When people break their promises to themselves and to others about their use of alcohol and other drugs, and when most aspects of their lives have been damaged by their disease, this self-hatred is accompanied by guilt, self-pity, and anger, and the whole gamut of uncomfortable feelings increases their need for the relief that drugs have supplied.
- Society, especially the helping professions, has accepted the self-evaluation of these people. In doing so, we push them farther into the welter of destructive feelings from which they have learned to escape with the drug. Our experience with them seems to justify our feelings. They are undependable; they manipulate us;

they don't support their families adequately; they are a hazard on the highway; they break promises seemingly made in all sincerity. They are so adept at avoiding the pain of accepting reality by creating alibis that making up plausible stories becomes a habit. The list of things they do or don't do that we don't like seems endless, and above all, they don't follow our recommendations. To top it all off, we who want to help our patients be more comfortable sometimes compound the problem by prescribing other chemical comforters.

The treatment goal is to convince alcoholic patients that they have the disease alcoholism or another addiction; that they can never again use the drug safely; that their physical, social, and spiritual problems are part of the disease; that they can become worthwhile people again; and that active membership in AA is the best way to become and to remain happily sober. In addition to informing the patient about alcohol and other drugs and reducing the physical distress as much as possible through proper diet, rest, and exercise, professionals must attempt to interest patients in AA while they are still in treatment.

The Alcoholics Anonymous program should be explained by an informed member of the professional staff, who may or may not be an AA member or a recovered addict. It is not necessarily an advantage for the interpreter to be an AA member, but he or she must know and be enthusiastic about the AA program. As was stated previously, he or she should be familiar enough with the AA books and pamphlets to see which one fits a given patient's needs at the time. An interpreter who is a member of AA should disassociate his or her position in the institution from AA membership, since he or she is performing this service as a professional.

Other ways to ensure continuing education and support for clients include:

- Holding AA meetings in the institution put on by "outside" AA members. These may be more productive if professional staff is not present. Certainly, the meeting should not be chaired by a counselor who may be an AA member. The AA group that handles the meeting should be carefully selected for its understanding of the policies and program of the institution.
- Carrying patients through the first few Steps of the AA program while they are under active treatment. This procedure is followed in some hospitals and treatment centers that are intensely AA oriented.
- Helping the patient in treatment make contact with an AA member with whom he may have some common ground other than addiction—for example, education, work, or neighborhood—and who may introduce him to an AA group after the return home.

It is equally important that AA members attempt to work with alcoholics while they are still in treatment. Treatment professionals should know some AA members who would be willing to be "on call"—to meet with people who might need help or who need to talk. Whether or not AA members conduct their work *within* the treatment setting depends on the people involved. A great many treatment centers employ counselors who are members of AA. These are people who have had proper training and who are sufficiently experienced that the head of a treatment organization could be justified in employing and paying them for their expertise apart from and in addition to their AA membership; but, to employ them simply because they are members of AA would be a mistake. The following conditions should prevail if the AA member is to be a counselor in the treatment setting: He or she should have at least 5 years of continuous sobriety; should be well thought of in the AA community and attending and participating in AA meetings; should not be receiving or need psychotherapy; and should be trained broadly in the field of alcoholism, as well as in the policies and practices of the institution of which he or she is a part and in the rationale for those policies and practices.

AA volunteers who help in the treatment setting—and I emphasize volunteers in contrast to counselors who are AA members—should be carefully selected, with at least a year of continuous sobriety and without significant personality problems; they should be well known and liked in the AA community. In my opinion, unless the person in question has had at least 3 to 4 years in AA, it is not always advisable to put him or her in that setting. There are many stresses to the AA person in a treatment center. Newer members may be antagonistic to treatment and medical personnel, especially if they had bad experiences with those people in the past. They may become frustrated when their superiors in the treatment setting don't seem to understand what the alcoholic patient is going through or when alcoholic people who they're trying to

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help go out and get drunk. Until these members can find maturity in AA, and feel secure in their own sobriety, it can be a negative experience for both the treatment program and the individual.

Many treatment agencies are using AA counselors and volunteers with increasing success. In some hospitals, AA and Al-Anon members are volunteers in emergency rooms. They make the initial contact with alcoholics when they are brought in and stay with them while they await treatment. The acute alcoholic reacts negatively to any sort of hostility (often directed at them in the emergency room setting); the AA member has gone through this and knows better how to deal with it.

Hazelden has the longest and most successful history of professionals and AA working together that I know of. This is a broad, medically oriented and staffed 28-day program that has a close working relationship with AA locally and nationally. The Chit Chat Foundation's program has not been in existence as long, and in the induction setting there are doctors, radiologists, psychiatrists, and counselors who have been educated in AA's principles and processes. In fact, a number of their physicians have been AA members. I believe AA volunteers are used there as well.

While in many places the working relationship between treatment programs and AA is flourishing, there are some issues that must be resolved to ensure future development of this mutually beneficial cooperation. The most substantial problem facing AA today is the large number of people seeking help in AA who are dependent on more than one chemical. Most longtime AA members have learned by experience that psychotropic chemicals often lead to a return to alcohol, so AA has been opposed to its members taking medication or mood-changing drugs of any kind. For some, this even includes aspirin. While this is an extreme position that few of us accept, it is understandable. Counselors and AA members must learn that some people who are addicted to alcohol have serious problems in addition to their alcoholism which require treatment, and that they must occasionally accept use of drugs and medication, and that this does not compromise their loyalty to AA.

At the same time, professionals will have to become even more involved with AA. In the 1980 survey, members were asked if their doctors had ever been to AA meetings. Eleven percent said yes, 12 percent said no, and 74 percent responded that they didn't know. This shows not only that many alcoholic patients have less-than-candid relationships with their doctors but also that treatment professionals need to get more involved with AA. I've been telling AA members for years, "sponsor your doctor, your boss, your clergyman, or your policeman. Bring them to AA meetings. Do everything you can to help us overcome the stereotype of the drunk."

We are doing better in our working relationships than we did in the past, and more people are recovering to happy sobriety. The surveys of AA membership in 1968, 1971, 1974, 1977, and 1980 have shown a gradually increasing number of members who have come into the fellowship through referral from a physician or treatment agency. In 1968, 19 percent of our members were referred to AA; the 1980 survey showed that figure increased to 26 percent. Also, the 1974 and 1977 surveys show that many have found treatment from a psychiatrist or spiritual counselor helpful in meeting personal problems while they have remained active in AA. This is very gratifying, as it shows that rigid attitudes are softening, and more people will recover permanently to sobriety. When the blanketing effect of alcohol is eliminated, some deeper problems may come to the surface, where they can be recognized and treated, helping the alcoholic avoid returning to the drug.

Reunions once or twice a year, when the former patients return for an afternoon or evening of sharing with current patients, staff, and other "graduates," are great morale builders for everyone. Hospital board members and all others who are part of the hospital administration, both lay and professional, will become enthusiastic supporters of the whole enterprise when they see the results—recovery of those they formerly considered hopeless nuisances (to put it mildly) to a quality of life and happiness that is most attractive—the sort of recovery we crave for all our patients, but rarely achieve on our own. □

"Self-help is the growing practice of people providing their own goods and services rather than relying entirely on professionals, government, or business. . . .In isolation from other social values, self-help is merely a principle of survival."
From Self-Help in Perspective by Stuart Langton, Citizen Participation 3(3): 1982

A Self-Help Program For Women Alcoholics

Jean Kirkpatrick, Ph.D.

The self-help movement in the United States came into full glory with the founding of Alcoholics Anonymous in 1935, and even though it took several years for this self-help program to reach its stride and prove its ultimate value, self-help in this country got off to a remarkable start. In recent decades we have seen a plethora of self-help programs dealing with ailments, diseases, and afflictions of almost every kind.[1]

Why is self-help so increasingly popular? Perhaps the best answer is that it is effective. Certainly it is inexpensive, or I should say, "cost effective." In addition, it does something that professional help can never do: it provides a means of connecting with peers in an informal and nonprofessional setting. Professional costs for therapy of every kind have escalated radically, and treatment is administered by persons who some patients perceive as aloof professionals.

For alcoholics in particular, self-help groups have proved successful in supporting the requirements for recovery by reversing and eliminating those feelings of isolation that so ravage the alcoholic. Self-help groups erase the alcoholic's feelings that he or she is the only one suffering from alcoholism. By meeting with her peers, the alcoholic woman finds a sympathetic group with which she can identify, and one that provides the sociability and conviviality she once sought in a cocktail lounge or bar room or at a party. More important, the alcoholic comes to know moral support, and her self-pity is erased. Negative feelings, such as guilt and remorse, seem to be alleviated because others share these feelings.

The experience of attending a self-help group meeting begins to put discipline back into the alcoholic's life, something that is just as important as all of these other factors in the recovery process. An interesting aspect of self-help is that the group process itself can work recoveries without the alcoholic's even following a special program. Although this is by no means the rule, it reveals much about some of the needs of the alcoholic.

Alcoholics Anonymous has been the dominant self-help resource in the field of alcoholism. In 1975, Women For Sobriety (WFS) came onto the scene, providing a self-help program for women alcoholics (Kirkpatrick 1981). Its immediate popularity confirmed that women alcoholics often have very different problems and needs than do male alcoholics, and that a different kind of program was needed with emphasis on self-imaging to develop feelings of self-value and self-worth rather than on developing humility. The latter concept engenders and nurtures feelings of guilt, the very emotion that is so self-defeating to many women alcoholics.

The WFS Program

Based upon Thirteen Statements of Acceptance, the WFS Program is an affirmation of the value and worth of each woman. The statements set out goals for a change from negative feelings to positive affirmations. It is a program that leads each woman to practice positive self-imagery,

[1] Make Today Count for cancer patients, Reach for Recovery for women who have had mastectomies, Mended Hearts for surgical heart patients, Recovery for former mental patients, Smokenders, Weight Watchers, and many others. In his book *Helping Ourselves: Social Solutions to Global Problems* (1981), Stokes estimates that more than 10 million Americans belong to self-help groups focusing on overcoming psychological and physical problems.

seeing herself as forceful and compassionate, assertive and warm, and resourceful and responsible (Kirkpatrick 1978).

The WFS program puts the responsibility of staying sober directly upon each woman, while providing a hospitable, understanding setting in which to do so. She accepts her problem, alcholism, and then effects a sweeping change by casting aside her former images of her self. Many alcoholic women feel "I'm nothing," "I'm no good," or "nobody loves me." Virtually all women have some self-image problems, but a great many alcoholic women suffer from devastating feelings of guilt, anger, suppressed rage, and total defeat. Often even before these women begin drinking heavily they are experiencing feelings of being unlovable, worthless, unwanted, unloved, and uncared for.

The WFS program is based upon metaphysical philosophy. The Fifth Statement, "I am what I think," is the entire basis for the program. Because many alcoholic women feel unloved, uncared for, and incapable, they act as if they are unloved. It is essential to change this self-perception if they are to recover from alcoholism. Practice and time will help bring about the miracle of recovery and of positive self-image for that alcoholic woman. Her predominant feelings of guilt, depression, rejection, and helplessness will be overcome and recovery can take place.

The high rate of relapse among women alcoholics in many cases may be because treatment programs do not always address the negative self-image women have. Programs may get the alcoholic woman sober, but unless she is given reasons for and solutions to her self-image problem, she will not be able to maintain her sobriety once she is out in the world of temptations, where feelings of worthlessness, powerlessness, and loneliness combine to precipitate the downward slide into oblivion. Feeling like a nonperson makes recovery impossible.

Unfortunately, society often reinforces these attitudes; too often there is a perception that the alcoholic woman "got what she deserved." Alcoholism in women is regarded more moralistically than it is in men, making recovery more difficult in many cases for women.

Men are more likely to be seen as courageous in their recovery. They are viewed as being strong for overcoming their alcohol problems, and they are often helped with their recovery by those who surround them. However, the alcoholic woman is often not helped enough by those around her. In many cases, in fact, she is alone; this adds to her negative self-image as she comes to believe that she is a nobody for whom no one cares enough to stay and provide help and emotional support.

Because of this sense of isolation, self-help groups are especially vital to the recovery of the female alcoholic. Female alcoholics also benefit greatly from participation in a self-help program group that is directed toward and limited to women, whether it be WFS or something else. Women need the opportunity to be with other women who can share their feelings, problems, and needs.

Jean Kirkpatrick, Ph.D., is the founder of Women For Sobriety, the first self-help program devoted to female alcoholics. Based in Quakertown, PA, she serves as executive director in that organization and addresses the needs of women alcoholics in general by lecturing, writing, and editing the bimonthly magazine, Sobering Thoughts.

WFS and AA: Complementary Approaches

Inevitably, comparisons are made between the WFS Program and Alcoholics Anonymous (AA). Although there are extreme differences between the programs, they are neither mutually exclusive nor contradictory. We at Women For Sobriety emphatically believe that every woman alcoholic should use the WFS Program, since it came into being from a woman's experience. We believe that participation in AA, as an extra measure of growth and recovery, is an excellent option, and we encourage it. But we firmly believe that women must be in women-only groups and that there must be a program designed to provide this experience.

The reasons for this are numerous. The problems of most women are tied to the male-female relationship, and these problems cannot be talked about or thoroughly explored in a mixed group. Too often in mixed groups the men dominate and the women have little chance to express themselves or to speak about what is truly bothering them. Often men do not want to hear about crying children and the frustrations of daily life. They consider the frustrations of women to be minor and not deserving of a place in the group discussion. More and more, treatment facilities are coming to see the truth of this situation and the value of women-only groups, but this change is occurring much too slowly.

Knollwood Center in Riverside, California, is an excellent example of how effective the

women-only group can be. There the WFS program is one part of the treatment administered by therapists and counselors already in the facility. These professionals serve as group moderators in daily WFS sessions. Other facilities open their doors to alcoholic women in the community so they can attend WFS meetings 1 day a week with clients in the treatment program.

To use the WFS Program, we suggest that each woman arise 15 to 20 minutes earlier than usual each day so that she will have meditation and affirmation time. During this period she reads through the program and then concentrates on one particular statement that she will use that day. Also during this period of time, she affirms: "I am a capable, competent, caring, and compassionate woman and have much to give to others." We make this same affirmation at the close of our meetings.

More specifically, the WFS program emphasizes:

- The necessity of taking responsibility for one's self
- The need to live in the present and future
- Emotional and spiritual growth as the main object of life, even though the program does not refer to a Higher Power
- The need for women to speak out about their alcoholism whenever possible and to appear in the public eye: although we protect the anonymity of any woman who seeks it
- The dignity and positive self-image to which our members are entitled; for example, I would introduce myself by saying, "My name is Jean and I'm a competent woman."
- The use of meditation, taking vitamins, avoiding candy, drinking little or no coffee, and cutting down on smoking

Under certain circumstances, we urge women counselors and therapists to lead our groups, which never number more than 10 women. We do not ever speak of how many meetings one must attend or for how long. We believe that with emotional and spiritual growth such as WFS provides, one need not be tied to a weekly meeting for the remainder of her life. We never suggest that anyone stop taking medication unless it is a psychotropic drug.

Although there are differences between these two self-help programs for alcoholics, many of our members use both programs simultaneously and find no conflict in doing so. In fact, as an organization, WFS urges women to get as much help as they possibly can, believing that failure to do so is the reason that so many women relapse so often. For those women who have been or who are members of AA, the WFS program frequently adds a brand new dimension to their sobriety; likewise, AA provides new opportunities and outlets for women who previously attended only WFS meetings.

With federally funded programs all but a thing of the past, and with private treatment programs becoming too costly for many women, there is an ever-increasing need for self-help programs that offer lifetime support at virtually no charge.

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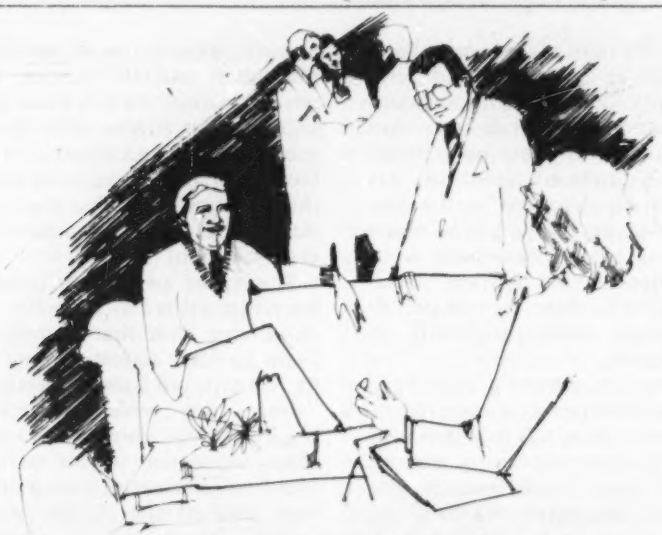
WFS Acceptance Program

1. I have a drinking problem that once had me.
2. Negative emotions destroy only myself.
3. Happiness is a habit I will develop.
4. Problems bother me only to the degree I permit them to.
5. I am what I think.
6. Life can be ordinary or it can be great.
7. Love can change the course of my world.
8. The fundamental object of life is emotional and spiritual growth.
9. The past is gone forever.
10. All love given returns twofold.
11. Enthusiasm is my daily exercise.
12. I am a competent woman and have much to give others.
13. I am responsible for myself and my sisters.



Parent Action Groups: A Prevention Resource

Editor's Note: This article includes excerpts from a draft report, "Concerned Parents Groups," prepared by Associates Consultants Inc. Interviews with leaders in the parents' movement were conducted by Jill Vejnoska, staff writer.

Suddenly Mr. Greenstein blurted out, "It angers me that we are expected to sit back and take this—this victimization of our children. My children are still dependent on me; they still live in my home. I refuse to accept that our world cannot be one of mutual respect and healthier values for parent and child." A mother warned about how unified and organized the peer world is. . ."Most of their time is spent with their friends, at school, and away from home, and current peer attitudes largely determine their own." "Well, then," interjected Mr. Greenstein, "let's outunify and outorganize them!" Laughing shouts of "parent power" led to vows to outmaneuver "peer power" and to overcome "dope power."

This excerpt from the National Institute on Drug Abuse (NIDA) publication *Parents, Peers, and Pot* identifies the societal elements that encourage youngsters to experiment with and often abuse substances. More important, however, it suggests that something can be done to counter the effects of the organized "drug culture" of which many of today's youths are a part.

In recent years, parents have come to recognize the importance of joining forces to prevent youthful substance abuse. They have formed parent self-help groups.

A draft report on "Concerned Parent Groups" prepared in 1981 by Associates Consultants indicates that most of the groups have sought to make young people aware of the risk associated with drug use—and in some instances alcohol use. According to the report, "The perceived need for such a structure grew out of increasing concern on the part of parents that their children, for many reasons, were indulging in the use of drugs, particularly marijuana, and from a feeling that, as parents, they did not control many of the societal factors affecting their children's lives. Parents perceived that major elements of society were accepting drug-using behavior as a means of coping with an increasingly complex social environment. . . .

"As more and more parents began to seek assistance outside the traditional drug abuse prevention and treatment system, they discovered other parents who shared the same frustration and concerns. The occurrence of personal and community-wide problems related to drug abuse galvanized them into action. Parents at first involved just their friends, then began reaching out to other families, who became just as committed to preventing drug use among their children."

Today, there are approximately 2,000 or more of these groups. While their early efforts focused almost exclusively on banning the sale of drug paraphernalia, the objectives of many parents groups have broadened to include a wide range of activities designed to prevent and minimize alcohol and drug problems. The philosophy, however, is generally consistent: *any* use of alcohol or other drugs by young people is illegal and should not be sanctioned by society.

Note: To order single copies of "Parents, Peers, and Pot," write to the National Clearinghouse for Drug Information, Room 10A-56, Parklawn Bldg., 5600 Fishers Lane, Rockville, Maryland 20857.

Activities of Parent Action Groups

Prior to the emergence of this *organized* parents' movement in the late 1970s, parents were extensively involved in substance abuse treatment and prevention efforts. However, the emphasis previously had been on participation by parents in treatment and prevention programs, or in established, multiple-membership, even multipurpose, organizations. The emphasis in the burgeoning parent movement of today is clearly upon parent-created, parent-directed, and parent-oriented groups. Their activities are now popularly labeled as "parent action" and "parent power" with a concentrated focus on direct action by parents at their own initiative. A unique aspect of this parent involvement is the potential (as yet unrealized by many groups) for a concerted, well-organized attack on the social conditions that contribute to substance abuse, according to the report.

Generally, parent groups have approached prevention by focusing on social conditions that support or encourage drug and alcohol use. These include the mixed messages transmitted about substance use, suggestions that such use is "normal experimentation" or a "rite of passage" among adolescents. Parent groups have attacked song lyrics, literature, and media campaigns that promote the idea that substance use is fun or a form of entertainment.

The types of groups parents have formed are as varied as the conditions that first compelled them to take action. According to "Concerned Parents Groups," "there are many different organizational models of self-help, volunteer parent action, and family-oriented groups that have formed specifically to ad-

Parent Groups And Prevention Programs: Growing Cooperation

At both State and National levels, efforts are being made to unify elements of the parent movement, as well as to encourage working relationships between parent groups and prevention programs.

The National Institute on Drug Abuse (NIDA) recently sponsored two regional Family Collaboration Workshops to encourage State authorities and family groups to work together to prevent drug abuse among young people; two additional workshops are planned. The workshops, in Virginia, California, Texas, and Iowa, focus on bringing together personnel from State drug and alcohol agencies, local prevention programs, treatment agencies, and organized parents groups. Sponsored by NIDA's Division of Prevention and Treatment Development, the family collaboration workshops are intended to establish collaborative movements in each State to deal with drug abuse problems families face. In addition to evaluating various State collaboration models, conference participants examine different family group prevention strategies and review existing resources, training materials and facilities, a NIDA spokesperson said.

At the State level, the Pennsylvania State Office of Drug and Alcohol Programs (OADP) has contracted with Eagleville Hospital to administer the Parent Resource Project, a 6-month operation focusing on the need for identification, coordination, and cooperative planning of parent groups across the State. Steering committees—composed primarily of parents—studied needs assessment questionnaires filled out by parents throughout the State, and planned two conferences for the eastern and western portions of Pennsylvania. Parents attending these conferences shared information and strategies concerning prevention and intervention, developed working relationships with community-based programs, and learned about resources applicable to their needs. Proposed followup activities to the conferences—held March 25-26 and April 5-6—included developing newsletters that describe parent activities and resources, compiling a directory of parent groups in Pennsylvania, and holding a strategy planning day to ensure continued interest in and activity related to the cooperative parent group structure.

—Jill Vejnoska
Staff Writer

dress the issue of drug abuse prevention, or that have included drug abuse prevention as one of several social action initiatives."

"The impetus from many parent groups was the awareness by parents of the widespread availability and use of drugs in local schools their children attended," according to the report. "It shocked many parents that the educational system, a mainstay of social stability, was being threatened by the drug culture. Therefore, these concerns caused many parents to act to insure that their children could attend school in a 'drug free' environment." In March 1978, for example, a Thousand Oaks, California, parent group organizer joined two other mothers concerned about the prevalence of drug and alcohol use by school children and sponsored a community meeting to discuss the problem and possible solutions. The outcome of the meeting was a consensus that widespread community involvement was needed to prevent youthful drug abuse, and the Conejo Valley Drug Abuse Prevention Network was formed.

"Other groups formed as a primary prevention effort, employing education and information sharing as major activities of the group," according to the report. For example, CASCADE, Inc., a black parents self-help group serving Atlanta's southwest communities, was founded on the principle of building effective community coalitions to respond to problems of mental health and substance abuse. This group also provided prevention and educational services to the community. In Georgia, DeKalb Families in Action (DFIA) speaks to local PTAs in the county about drug use among youth and about the medical effects of marijuana and other drugs. As part of this activity, a DFIA Task Force created the DeKalb County PTA Committee on Alcohol and Drug Abuse and selected two schools in the county to develop a pilot program to educate parents, teachers, and students about the adverse effects of drugs and alcohol on children and teenagers. In Nebraska, a community program, PRIDE-Omaha, operates school and neighborhood teams that provide a continuous program of events for parents and youth including prevention education, and an associated parent organization works directly with a host of treatment and prevention programs in alcohol and drug abuse, probation-parole agencies, and other law enforcement, health, and mental health groups in a variety of activities to provide services and promote awareness.

Naples Informed Parents in Florida presents its own regular drug education programs for the community, at all school levels, while also participating in the elementary school's Preventicare program for 4th through 6th graders and in the special youth programs sponsored by the Community Mental Health Center (CMHC) and the Sheriff's depart-ment. The Concerned Citizens for Drug Education (Indiana) parent group developed a "Positive Self-Esteem" program in the school system for grades K through 12, starting with a grade 9 through 12 pilot program in 1980-81.

While there have been no empirical studies on the impact of the parent action movement on communities, subjective reports point to the following changes:

- Heightened community awareness and understanding of the substance abuse problem
- Improved parental understanding of substance abuse and the parental opportunities for interaction
- Greater cooperation among service agencies
- Stimulation of improved services and the creation of a climate in which positive programming was possible
- Getting schools, agencies and organizations, and parents to adopt a nonblaming approach to abuse prevention and intervention that has improved the climate for prevention programming
- Changes in the ways in which children now view substances
- Providing the momentum for changes in school policy regarding drugs in schools; groups have reportedly been instrumental in getting schools to enforce stricter discipline codes and in getting them to act more directly and cooperatively with parents on the issue
- Enhanced parental capability to cope with the problem and provide assistance to their children, even in families where substance abuse by youth continues.

An example of the benefits of the self-help movement exists in Northside (Georgia) High School, where staff worked with the Unified Parents Group to tighten school discipline and raise educational standards. The parents credit this working relationship for a "complete turnaround in attitudes and behavior. . .Within 3 years, there has been a dramatic reduction in drug and alcohol use, a dramatic rise in SAT scores, math and reading skills, enrollment in advanced science and foreign language courses, and participation in athletic and extracurricular activities," accord-

ing to the Associates Consultants draft report.

From small suburbs to large metropolitan areas, parent groups have been successful in increasing public awareness of the drug abuse problem and in creating a more positive climate for prevention programming, the report states. "The parent action movement is generally considered to be one of the most dynamic developments of the last decade, and potentially one of the most significant prevention activities of the eighties. But there are many unanswered questions about the movement's continuity (as national and statewide prevention initiatives), the scope of appropriate activities, the actual impact the various activities have upon drug and alcohol prevention, and the 'fit' between traditional, institutional prevention programs and parent group activities."

Networking

Very recently there have been efforts by some of these groups to band together to establish a national presence. Bill Barton, president of the Washington (DC)-based National Federation of Parents for Drug-Free Youth, says his group was established 2 years ago. According to Barton, "The federation arose from the realization of parents attending the 6th Annual Southeastern Drug Conference in Atlanta that we needed to bring together the parents who had started groups in their communities. It was essential to have a clearingh e, we decided, to pass on good literature and advice, and to help parents create a national voice in legislative matters. We are concerned with reinventing the wheel as little as possible. We have a volunteer board of directors of 25 people, most of whom are parents, but some of whom are just interested in preventing drug problems. What is most interesting about our board is that 60 percent of the members are from families in which there have been *no* alcohol or drug problems. I think this is understandable if you realize that our primary goal and object is education and prevention. We, as parents, are not qualified to be interveners (unless it's very early intervention) or to provide treatment. It's prevention we're interested in."

At the State level there are also increasing efforts to develop networks. Beverly Kinard, president of the Colorado Federation of Parents, Inc., reports, "I give talks throughout the State about my personal experiences with drugs and alcohol and about my experience as a parent group member. With each talk I give, I start a new parents group. We have a newsletter that goes out every month. If there's something we want to bring the parents groups up-to-date on—new findings, reports, developments in Washington—we contact them by mail. If it's something really important, we have a phone network. Within 45 minutes I can reach 35 parent groups throughout the State, who pass the news on to their members. In April we have a rap session in which parents come together to share experiences and make suggestions. The newer people listen to the older, more experienced members, and gain a lot from what they have to say. When something important happens, say, in Washington, we can use our network to reach thousands of parents, who are voters, throughout the State. We can get our message across on TV—the media are very cooperative—in the churches, and if it's something that has happened in Washington, the office of the National Federation of Parents will get the pertinent information to us, we'll send it to our people, and they'll copy it and get it out to all their members. When we hear about new drug information or new studies, we photostat it and get it out to our people.

"I've set up an office at our headquarters that contains American Council on Marijuana and National Federation of Parents literature and government publications. The office also furnishes films, literature, and a 24-hour service for parents in trouble. Anyone is welcome to come in and use our materials and cry their eyes out if they want to. We then hand them resource lists of treatment programs in their areas; we don't pick one for them. We tell them that it's their decision. When new information becomes available, we sit down with experts and talk with them about it so we can evaluate it for our re-

Program Linkages

While most if not all parents groups have sponsored workshops and seminars that attracted community participation, and there is ample reason to believe that most, if not all, parents groups have been quite successful in raising community awareness, there are considerable differences in the degree to which individual groups have "networked" within their communities, according to the Associates Consultants draft report.

Groups have established linkages with a variety of community organizations including city councils, law enforcement agencies, the school system, religious groups, civic and fraternal organizations, hospitals and

other health care providers, and alcohol and drug abuse treatment and prevention programs. Parent group relationships with community organizations have been developed through various methods: representation on parent groups boards, participation in workshops and seminars, information dissemination, cosponsorship of drug abuse prevention activities, etc. The approach of parent groups in networking the community has generally been to work within the existing community educational, law enforcement, or other structures, rather than to attempt totally independent action.

In Colorado, for example, Kinard's group works with the Kiwanis organization to expand its list of contacts in various communities and with the Denver Police Department to develop prevention-related films and tapes and facilitate their distribution throughout the city.

Numerous groups have achieved notable levels of interaction at both the community and State levels, and continue to maintain their independence, the report notes. PRIDE Omaha, for instance, has developed very extensive linkages with existing treatment and counseling centers, schools, medical organizations, the media, law enforcement agencies, other health and social service programs, hospitals, volunteer groups like Al-Anon, and regional human services agencies. PRIDE not only participates in school drug education and prevention, but also has been involved in curriculum development.

Naples Informed Parents in Florida has developed collaborative relationships with a variety of community groups and agencies including the police, the schools, the medical society, the community mental health center, and the city council. In addition, several civic groups and businesses have made donations to support the group's efforts. Naples Informed Parents has a well-established relationship with the county sheriff department's school-based youth programs. The Sheriff's Youth Relations, Youth Deputies, and Youth Leaders programs are unique. Through the Youth Relations programs, a uniformed officer, stationed at the school, offers courses on alcohol and drug abuse, the law, law enforcement procedures, and traffic safety which are all part of the formal curriculum. In addition, the trained officers (who do not enforce school disciplinary codes) provide counseling to youth in trouble with the law, or with drug or alcohol problems, or parental problems, and have organized the high school students into various intramural sporting activities (which the officers coach), as well as recreational activities. For the lower grades there is the Youth Deputies program, which emphasizes officer-led recreation activities for younger children, lessons on bike safety, hiking trips, etc. The Youth Leaders program provides training for high school youngsters who want to work with the younger deputies. Repeated surveys show that the three programs have an 85 percent or higher approval rate among students, parents, and faculty. (Several current members of the Sheriff's Department were Youth Deputies and participated in the Youth Relations program during their school days.)

Parents Really Care (PRC) in Florida has been responsible for introducing into its local school system the "Quest" program (a

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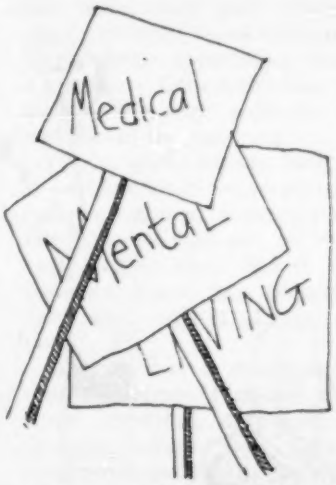


"Many of the issues around which self-help groups organize—chronic medical conditions, mental illness, problems in living—are not the ones that receive major attention in society. Professionals, volunteers, and public and private agencies who have watched (or ignored) this movement from the sidelines now wonder what their role is, if any, in group formation and development. Nor has this movement required the financial support that other forms of human service depend on. . . .Whether the self-help groups are viewed, in Albert Schweitzer's terms, as 'fellowships of pain,' or in Paul Antze's words, as 'fixed communities of belief,' they have a tendency to generate great initiative, commitment, and compassion. They manifest a quality of dedication that approaches the moral equivalent of war that William James sought in our nation at peace."

From Leadership in Self-Help/Mutual Aid Groups by Leonard D. Borman, Citizen Participation *3(3): 1982*

Alcoholics In The Helping Professions: Helping One Another

Surveys from the past few years indicate an increase in the rate of alcoholism among the "helping" professions—physicians, nurses, dentists, lawyers, social workers, and clergy. Professionals in these fields and in the alcoholism field give a variety of reasons for this increase, but several common factors are apparent, contributing both to development of the disease itself and to difficulties in recovery.

Probably most often cited is the stress factor involved in these occupations. Doctors and nurses, especially, are placed in situations where great responsibility rests on them as they make life and death decisions. Lawyers are expected to win their cases and judges to make the right decision every time. Social workers and other counselors, as well as members of the clergy, often feel they must behave as role models in addition to advising those they serve.

It appears that certain working conditions contribute to development of alcohol problems and other stress-related problems, and that these predisposing conditions are characteristic of the work environment of many health care and social service professionals. According to Trice and Roman (1978) these risk factors include the following:

- Absence of clear goals—lack of readily identified criteria to evaluate work and little feedback to worker about performance.
- Freedom to set work hours—enabling the client to cover up what would otherwise be absenteeism.
- Low structural visibility—job requires time away from others, leading to estrangement from fellow workers and from people important to personal life of employee.
- Work addiction—living, breathing, and eating work.
- Occupational obsolescence—when the meaning or value of work is gone, drinking may replace that.
- New work statuses—new roles tend to be ambiguous; the worker can structure it himself or herself to accommodate problem drinking.
- Required on-the-job drinking—to entertain clients or a benefit to job (e.g., for bartenders).
- Mutual benefits—when it pays one worker to see another develop a problem so that he or she may advance at other's expense in a power struggle.
- Reduction of social controls—drinking is socialized as a way to reduce tensions for workers.
- Severe role stress—when the job creates great pressure, e.g., due to burdening workload.
- Competitive pressure—when competition for organizational rewards is great.
- Presence of illegal drug users—the atmosphere of

secrecy and breakdown of norms may facilitate problem drinking.

There are also work-related factors that serve as barriers to intervention treatment. Affecting both the development of alcoholism and its possible treatment and cure is the position these professionals hold as advice givers. Doctors and lawyers especially seem unwilling to listen to diagnoses of their problems by others. This contributes to their refusal to recognize their condition and reluctance to hand their problems over to someone else for treatment.

Also, the risk of admitting need and seeking help can be so great—the potential loss of licensing—that doctors, nurses, lawyers, and dentists with alcohol problems often do not seek help they need.

In the early 1970s, groups of professionals began organizing to help themselves. The groups bear titles such as "Lawyers Concerned for Lawyers" and "Disabled Dentists Program." In most cases, the impaired professional is helped by others in his or her field who themselves often have overcome alcohol and/or drug abuse problems.

In some cases, such programs resemble employee alcoholism programs (EAPs) in that they carry a disciplinary component. In most instances, such professional groups are peer-to-peer assistance efforts. In all cases, self-help is an element of the program.

Such programs have been successful because they allow the professional to seek treatment without jeopardizing his or her professional status; they help professionals who may either work alone or in an organizational setting where they would not be willing to risk admission of a problem for fear of losing their professional prestige, and they permit professionals to see that other professionals have similar problems, helping them to deal with the stigma and guilt of alcohol problems.

Physicians

Most States have some sort of program for impaired physicians, ranging from referrals through the State Medical Society to formally organized, structured rehabilitation efforts. Fewer than 10 States have no program or have done nothing officially to address the problem.

Physicians who have recovered from alcoholism and now are helping others cite an additional factor making acknowledgment of their illness difficult: the willingness of colleagues and staff associates to give them second, third, and fourth (and more) chances, or even to lie outright about the reasons for a doctors's hospitalization or impairment.

In 1975 a national conference of the American Medical Association agreed to recognize impaired physicians—whether from alcohol, drugs, emotional problems, or a combination—as sick persons rather than as bad doctors to be expelled from the profession. Many State societies started organizing their own helping efforts at this time.

The impaired physician committees in the individual States publicize around-the-clock telephone hotlines. They encourage spouses, colleagues, hospital and office staffs, nurses, administrators, and pharmacists to report strong suspicions of problems to the committee. Once an impaired physician is identified, "confrontation teams" of doctors are sent to persuade him or her to obtain help voluntarily. Some State medical societies take an aggressive approach, in which the team visits and revisits a physician until he or she agrees to get help—even using threats if necessary. Others consider one visit from a team sufficient, regardless of the outcome.

Illinois and Georgia have led in establishing impaired physician programs. In many states, the program will act on referrals *from* the State disciplinary board but physicians are not referred *to* the board.

Georgia has a structured 4-month treatment plan with a full-time medical director, G. Douglas Talbott, M.D., also the program founder. The State program maintains liaison with the 27 county medical society auxiliaries, which refer about half of the impaired physicians who go to treatment.

The first month of a doctor's rehabilitation is spent at Ridgeview Institute, a rehabilitation center. The second month is spent as an outpatient at a halfway house, and the last 2 months are spent treating other alcoholics and addicted patients, mostly in low-income neighborhoods. The 4 months are followed by 20 months of "intensive surveillance aftercare."

For further information, contact Illinois State Medical Society, 55 E. Monroe St., Suite 3510, Chicago, IL 60603 or Medical Association of Georgia, Disabled Doctors' Committee, 938 Peachtree St., NW, Atlanta, GA 30309.

Nurses

The impaired nurse has only recently received attention from the alcohol and drug addictions profession and from professional nursing organizations. Nurses face much the same kind of stress as physicians, but because it is easier for them to move

from job to job, many times in private duty or other unstructured settings, they may be even harder to bring to treatment.

The Drug and Alcohol Nurses Association (DANA) and the National Nurses' Society on Alcoholism (NNSA) have been focusing in recent years on helping nurses with addiction problems. The American Nurses Association recently has reactivated a task force to investigate possible involvement on a national scale.

The annual meeting of NNSA last April was entirely devoted to the subject of the addicted nurse. Regional groups of NNSA have also been holding meetings focusing on this problem and acting as advocates in their communities.

DANA, which focuses on nurses who are alcohol- or drug-impaired as well as on those who treat substance abusers as patients, has members in 18 States and the District of Columbia. Members are currently preparing for their fourth annual meeting this fall. DANA's executive committee and the NNSA board are working to coordinate both groups' activities.

According to LeClair Bissell, M.D., a lack of employee assistance programs (EAPs) in hospitals and within organized nursing has hindered bringing nurses to treatment. EAPs have shown marked success in private industry, and their establishment within hospitals would help nurses throughout the country—especially if part of the policy was to provide treatment as an alternative to disciplinary measures, Bissell has emphasized. Where such programs are in place, they are as successful as in business settings, according to a NNSA spokesperson.

A recovered alcoholic, Bissell has been active in impaired physicians, social workers, and nurses programs. She feels that another problem for the addicted nurse is the "hostile environment" the health care profession presents for addicts, combined with easy access to drugs.

Some States have begun their own efforts to help impaired nurses. The Maryland Nurses' Association, for example, for the past few years has operated a telephone hotline.

For further information, contact American Nursing Association, 2420 Pershing Rd., Kansas City, MO 64108; National Nurses Society on Alcoholism, National Council on Alcoholism, 733 3rd Ave., New York, NY 10017; Drug and Alcohol Nursing Association, P.O. Box 371, College Park, MD 20770; or the State Nursing Association.

Dentists

Experts agree that dentists suffer the same stresses as other health care providers. But added to this is the image many people have of dentists as inflictors of pain or, at the least, inconvenience. Dentists are expected to take negative greetings in stride, such as when a patient says, "I hope I won't see you again for a long time."

Two other factors separate dentists to a certain extent from other health care professionals, according to some studies: the relative solitariness of their work (few work with associates) and the perfectionist attitudes that seem to occur often in this profession. Both can contribute to the dentist's reluctance to seek treatment and to the difficulty of identifying the impaired dentist.

In 1979 the American Dental Association (ADA) Council on Dental Practice was authorized by the ADA to act as a clearinghouse for information regarding alcohol and chemical dependency programs for the dental profession. States that have taken an especially active role in helping impaired dentists are Connecticut, Georgia, Minnesota, and North Carolina.

In addition to information about State activities, the ADA clearinghouse provides recommendations for hospital- and non-hospital-based residential treatment facilities. International Doctors in Alcoholics Anonymous, Youngstown, Ohio, is also a source for help.

In Minnesota, Dentists Concerned for Dentists (DCD), a group of recovering chemically dependent dentists, was formed in 1978. Their aim is to bring a message of hope and recovery to those of their profession still struggling with the problem. Ads are placed in the dental journals, although the organization is autonomous and not part of any professional association. All referrals are handled in a confidential manner. Counseling by a chemical dependency counselor is offered free of charge, as is pre-intervention counseling for family members and other concerned persons. The goal of the intervention is to confront the person with his or her alcoholic/chemically dependent behavior. Referrals are made to treatment centers and to AA. There is ongoing support in the form of regular meetings, and attendance at AA meetings is stressed.

The Disabled Dentists' Programm, located in Smyrna, Georgia (a suburb of Atlanta), treats all inquiries as confidential. Members of the treatment management team and/or a recovering graduate of the program,

along with support personnel as needed, attempt to persuade the impaired dentist to enter treatment. Program representatives act as advocates where necessary with the dentist's local dental society, State Board, or other agencies. So far, 35 people from 13 States have used the program. Treatment programs vary with the individual. The unique aspect of the program is its combination of individualized treatment and advocacy to help the person reenter the dental profession.

The Connecticut State Dental Association formed an Alcohol/Drug Committee to provide help to impaired dentists. To date, 8 of 12 dentists approached have accepted help. One of the committee's projects involved compiling a resource list of professionals, including recovering impaired dentists, in Connecticut, Massachusetts, and Rhode Island. The committee works closely with the State Dental Commission and the State Drug Control Division. Information, referrals, and support are provided by the group; it is not a "policing" agency. Volunteers play a key role in the committee's work.

For additional information, contact Connecticut Dental Association Alcohol/Drug Committee, 531 E. Center St., Manchester, CN 06040; Dentists Concerned for Dentists, 417 Minnesota Federal Bldg., Minneapolis, MN 55402; Disabled Dentists Program, Ridgeview Institute, 3995 S. Cobb St., Smyrna, GA 30080; American Dental Association, Council on Dental Practice, 211 E. Chicago Ave., Chicago, IL 60611.

Lawyers

From 10 to 20 percent or more of the Nation's lawyers may be alcohol impaired, according to estimates. Regardless of the number affected, experts feel that the stresses involved in the legal profession contribute greatly to the chance that an individual will develop an alcohol problem.

The first State to develop a program to help alcohol-impaired lawyers was California in 1973. Its approach, using techniques of Alcoholics Anonymous and peer counseling, has been adopted by other States.

The California State Bar's Committee on Alcohol Abuse, 13 lawyers and judges from throughout the State, runs the program. Any member of the State Bar requesting assistance is helped, and his or her rehabilitation is documented by the committee to assure that the impaired lawyer is at least attempting recovery. The program also refers spouses and children to programs such as Al-Anon and Alateen. Part-time consultants have aided with rehabilitation, and some physicians have donated their time. Program director Jack Sanow estimated in 1979 that similar programs were underway in 35 State and local bar associations.

In Minnesota, Lawyers Concerned for Lawyers (LCL), was formed in 1976. With a current membership of nearly 200, LCL operates autonomously, is not a part of any bar association, and reports to no other group. Autonomy and confidentiality are the keystones of its operation. Publicity is considered important, and ads are run in the State Bar Association journal. Referrals are carefully evaluated, and when a chemical dependency problem does exist, efforts are made to bring about an intervention. While entry into a treatment program is highly desirable, the purpose of the intervention is to confront the person with the reality of his/her behavior. The concepts of intervention, confrontation, and peer group influence have proved effective in helping attorneys, judges, and family members accept the help that is offered. LCL serves the legal profession as do industry-instituted programs. Its members offer ongoing help and support to one another through active participation in the organization, and AA participation is strongly encouraged.

The Legal Committee on Alcoholism of New Jersey was established in 1976 with two goals in mind: to educate members of the bench, the State and local bar, and the public on legal issues related to alcoholism, and to develop a project that would help alcoholic attorneys and judges to recovery.

The committee established a telephone line so that callers could speak with a recovering alcoholic attorney and, if necessary, be referred to someone geographically closer. In 1978 the committee became the Committee on Alcoholism of the New Jersey State Bar Association, and the project was named New Jersey Lawyers Concerned for Lawyers (NJLCL).

The goal of the NJLCL's intervention is to get the individual to agree to accept help. Activities include frequent lunches and recovery group meetings, based on AA principles. The program is organized on the same model as California's and Minnesota's and is sponsored by the State Bar Association.

While confidentiality is stressed repeatedly, publicity in State and county bar publications and the local press have helped bring persons to the program.

In other States, materials pub-

lished in the past few years indicate a growing awareness of the problem of the alcoholic lawyer. For example, the State Bar of Michigan has published "Lawyers and Judges Handbook on Alcoholism."

For information, contact New Jersey Lawyers Concerned for Lawyers, 310 Overlook Rd., P.O. Box 536, Boonton, NJ 07005; Lawyers Concerned for Lawyers, 417 Minnesota Federal Bldg., Minneapolis, MN 55402; California Bar Committee on Alcohol Abuse, State Bar, 555 Franklin St., San Francisco, CA 94102; or State Bar of Michigan, 306 Townsend St., Lansing, MI 48933.

Social Workers

In September 1980, 44 social workers met with LeClair Bissell, M.D., to discuss formation of a helping organization of their own. Social Workers Helping Social Workers (SWHSW) is open to professionals with master of social work (MSW) degrees and to MSW candidates, who have had personal experience with alcohol and other chemical dependencies. The group's purposes are to inform, support, consult, educate, promote, and attract membership, and to educate agencies and institutions where these professionals practice or receive their training.

Currently, there are about 136 members from 26 different States. There are chapters on the East Coast, based in Connecticut, and in the Midwest, based in Indianapolis. According to John F. Fitzgerald, MSW, Ph.D., national chairperson, attempts are underway to organize a West Coast chapter as well.

Also under discussion is the possibility of holding some statewide meetings. Fitzgerald stresses the group's intention to pursue "deliberate planned" growth to become the best possible model for a helping organization of this type. So far the social workers are the first group of mental health professionals to form a group to help one another.

A major project of the group has been to investigate in detail the effects of chemical dependency on social workers' clinical practices. The social worker's problems are similar to other professionals', agrees Fitzgerald. Within the profession itself there is a reluctance to confront the idea that impaired personnel are working in the field.

SWHSW, besides acting as a support group, publishes a newsletter for members and also is involved in such outreach activities as presenting papers at conferences.

The New York City Chapter of the National Association of Social Workers (NASW) has developed a committee to assist social workers who have alcohol, drug abuse, or emotional problems. The social worker can refer himself or herself for help and can obtain consultation about a colleague with a problem or ask the committee to contact a colleague with a problem. If one colleague calls, he or she must be willing to have his or her name used by the committee as initiating the request for a contact. If two or more colleagues request assistance, the committee will guard their anonymity in contacting the colleague with a problem. If help is refused, that is the end of the contact by the committee. The committee has written a guidebook called "Alcoholism Among Social Workers: Approaching a Colleague with a Drinking Problem," which has been printed by courtesy of the Metropolitan Insurance Company.

For further information, contact John F. Fitzgerald, Social Workers Helping Social Workers, South St., Goshen, CT 06756; or National Association of Social Workers, 1425 H St., NW, Suite 600, Washington, DC 20005.

Clergy

Clergy are increasingly providing counseling to alcoholics within their congregations or other spheres of contact. But where does a clergyman or religious brother or sister go for help with his or her own drinking problem? Society has begun only recently to view religious professionals as human beings who are subject to the same problems as everyone else.

Sister Maurice Doody of the Office of New Directions, Bronx, New York, a helping program for nuns, commented that a physician once told her, "I'd lose all faith in human nature if I found out a sister abused alcohol or drugs."

Programs to help members of the clergy are relatively scarce. Denominations whose basic tenets disapprove of liquor provide little help. Two of the denominations with more tolerant attitudes toward alcohol use—the Roman Catholics and the Episcopalians—have led in providing aid to their impaired clergy.

The National Clergy Council on Alcoholism and Related Drug Problems (NCCA) was organized to help Catholics, but is available for members of other denominations as well. NCCA's "primary objective and concern is to relieve pain and suffering, restore health and dignity, and return victims to productive and rewarding involvement in the important work" of their religious vocation, say Father John F.X. O'Neill, executive director, and

Brother Francis Crotty, associate director.

To accomplish these ends, Father O'Neill is encouraging Catholic bishops to establish employee alcoholism programs for the religious under their supervision. The EAPs would work as do those in private industry: an impaired clergy member would be told to get treatment or risk job loss. Treatment is available at several rehabilitation centers run by the church in America, such as St. Michael's in St. Louis, Missouri.

Most NCCA publicity is by word-of-mouth. The organization answers requests for materials and distributes an information packet on how to organize a local helping program.

NCCA personnel stress that an educated and alcohol-aware clergy is important for their parishioners' sake as well as for their own. This is also the goal of a commission established 2 years ago by the Episcopal Diocese of Virginia. The General Convention of the Episcopal Church has urged establishment of groups; composed of clergy, lay personnel, and persons familiar with alcoholism, establishes educational programs, decides how to intervene in cases of problem drinking in the laity and the clergy, and sets a policy regarding alcohol use at church functions and on church property.

For further information, contact Sister Maurice Doody, Office of New Directions, 2341 University Ave., Bronx, NY 10468; or National Clergy Council on Alcoholism, 3112 Seventh St., NE, Washington, DC 20017.

Other Helping Resources

Regardless of professional affiliation, the local Alcoholics Anonymous group is an option that is worth exploring when help is needed in dealing with a drinking problem. In addition to the professional-specific groups discussed in this article, other resources for those seeking to help impaired professionals include:

Center for the Well-Being of Health Professionals
200 Eastowne Drive, Suite 213
Chapel Hill, NC 27514

Promotes physical and mental well-being of health professionals by increasing awareness of professionals and the public of the stresses inherent in the health services system; educating professionals to prevent stress-related impairment; and coordinating efforts to improve the functional integrity of health professionals.

Alcoholics Anonymous (AA) World Services, Inc.
Box 459
Grand Central Station
New York, NY 10017
(212) 686-1100

Provides materials and information for local AA meetings and meetings for professional AA groups.

Al-Anon Family Groups Headquarters, Inc.
P.O. Box 182
Madison Square Station
New York, NY 10010
(212) 481-6565
Provides information and materials for families of alcoholics.

Alcohol and Drug Problems Association of North America
1101 15th Street, NW
Suite 204
Washington, DC 20006
Provides referral to local members working in alcoholism treatment, prevention, training, and research.

National Council on Alcoholism (NCA)
733 Third Avenue
New York, NY 10016
(212) 986-4433
Provides materials and referral to local and regional councils.□

References

Trice, H.M., and Roman, P.M. *Spirits and Demons at Work: Alcohol and Other Drugs on the Job.* 2d ed. Ithaca, NY: Cornell University, 1979.

Sharon W. Rohner, Staff Writer

"What are the possible roles of professionals working with self-help groups? One model is to see the professional as a facilitator of new groups. Professionals, however, typically have not been trained for this role—to perceive a need, help establish a self-help group to fill the needs, and then to disengage from the group. Special training is required to overcome some of their trained incapacities."

"Self-help groups vary enormously in their style or manner of functioning. Some require anonymity, some do not. Some have an advocacy orientation, while others insist that the problems are internal to the members and do not require any social or legislative intervention. Some are proprietary, some are not. Some have very specific methodologies like AA's Twelve Steps and its Twelve Rules, while others are much looser. Some are eager to expand, others are not. Some accept government support, while others prefer to raise money in different ways. Some are pro-professional, others anti-professional or adversarial."
From Training Professionals in Organizing Self-Help Groups by Frances J. Dory and Frank Reissman, Citizen Participation 3(3): 1982.

Perspectives *AA Member*
From page 5

ing home staff becoming aware of alcoholism and seeking out knowledge about alcohol problems. It's really a wide variety of people and no one particular type. □

> "But I really believe it's the personal contact between the patient and a member of AA that can be the key to acceptance of the help AA can offer."
>
> —AA member

Perspectives *Wenger*
From page 3

School systems can legally demand AA attendance and mandate treatment. So can the employer. A student or employee with leukemia has few choices; he or she is sent to treatment and is expected to cooperate with the doctor's recommendation. Alcoholism should be no different.

Q. Are there other ways the treatment program can help?

A. Treatment agencies are learning that mental health technology is not sufficient to effectively treat alcoholism. The mental health profession, notably psychologists and social workers, have contributed to the mistaken notion that alcoholism is a symptom of underlying pathology. Even today psychologists administer the MMPI to the recently dried out alcoholic and publish the idea that certain personalities get alcoholism. Actually there's predictable damage that occurs with the disease and our ex post facto research has only confirmed the damage. Mental health notions in research and treatment have led us down some blind alleys.

Treatment centers should use psychotherapy but also talk about the efficacy of AA principles, use the "Twelve Steps," and help the patient to commit himself to AA. Our hospital uses lectures on the Twelve Steps of AA, and while we do not maintain a formal connection with AA, we teach that AA is a winning ticket. We create an atmosphere in which people are free to talk about spiritual struggles. Psychotherapy is but an adjunct to our overall approach.

I recently administered a battery of psychological tests to 100 patients. It was a pre-test/post-test format, and we looked at the phenomenon of locus of control, purpose in life (roughly hope), and intrinsic religious motivation, a fancy word for surrender to a higher power. The results were interesting. While purpose in life didn't change during the course of the 28-day treatment program, and while locus of control didn't change during treatment, intrinsic religious motivation or surrender to a higher power, the central tenet of AA, did indeed change. Patients increased in surrender.

By discharge, patients who had grown in their willingness to surrender to a higher power also increased in hopefulness. Patients high in surrender were also most likely to return to aftercare. When we asked counselors to evaluate the patients regarding their ability to express themselves openly, those patients who had high intrinsic religious motivation were the same patients who counselors saw as open and honest. If you look at studies on sobriety maintenance, you'll find that hopefulness, attendance in aftercare programs, and self-congruence are pretty good sobriety predictors. Our alliance with this tenet of AA, "surrender to a higher power," has helped us to be a better treatment agency. We've introduced persons to an important concept that they can use in AA. We bridge the gap.

Q. Is there a particular "type" of person—alcoholic or family member—that most benefits from self-help group involvement?

A. AA seems to be the self-help group that works best for most, but as far as surrender to a higher power is concerned, our study indicated that there were some persons who had greater difficulty in embracing that idea. Those patients who had post-high school educations, for example, had the greatest problem in embracing the surrender to a higher power idea. It appears that those who had post-high school educations had alternative means for explaining their difficulties; they were better rationalizers. They could use other models to explain their problems. For the alcoholic locked in denial, an advanced education appears to be dangerous.

Another interesting finding of our study was that Catholics who had maintained their affiliation with the church had a difficult time with the idea of surrender to a higher power.

Now, it's hard to say whether persons with a post-high school education and Catholics have special problems with AA, but it appears that way.

Q. Are there any other differences—male-female differences, for example?

A. Women seem to have an easier job with the idea of surrender to a higher power than males do. That's difficult to explain. Maybe there is an emphasis among men on maintaining personal control. It's interesting that the first step of AA, the admission "we came to a belief that we were powerless over alcohol and our lives were unmanageable," in many respects clashes with some ideas of *personal* responsibility. AA begins with the contention that doing it *your* way hasn't worked. We therapists sometimes say to the alcoholic, "It's *all* up to you." Underlying assumptions of personal responsibility and AA's surrender to a higher power are in apparent conflict. AA, by encouraging surrender, gives back personal power. One million people are sober through AA, and there aren't many psychiatrists who can begin to point to a treatment record like that. Apparently, the assumptions of AA are important aspects of why that organization works. Those of us who work with people on a one-to-one basis would do well, I think, to pay attention to the underlying truth of AA. It's far more than folk therapy.

My study supports the idea that surrender to a higher power is a genuine personal event, that it can be measured, and that it has efficacy in treatment. Struggles around surrender can be overcome. Here at Talbot Hall we provide an atmosphere in which our patients can discuss their problems in dealing with surrender to a higher power. We're a spawning ground for AA members, and we're most successful with people who maintain AA affiliation after treatment. Sometimes I think of inpatient treatment as a kindergarten for the important work that must occur in the AA fellowship.

Most inpatient treatment agencies acknowledge the success of AA, and any treatment agency that wants to improve its treatment record would do well to look at the Twelve Steps of AA and ask how it can help patients utilize those steps in recovery. The explosion of self-help groups in the United States has come about through the inability of psychotherapists to respond to the myriad problems that are presented to them. If you look at the research on the efficacy of counseling, it's a bit embarrassing. We have come to believe that science can solve just about everything, and our dependence on that has given us acid rain, saccharin, and an allegiance to psychotherapy that is ill-founded. If consumerism standards were ever applied to psychotherapy, we counselors would be in trouble. Therapy alone has not been generally successful in helping individuals recover from alcoholism. The explosion of self-help groups has, I believe, been a response to the public's disillusionment with psychotherapy. Psychotherapy and self-help groups operate with assumptions and theories that are sometimes in conflict.

Before I was aware of the tremendous power of the Twelve Steps of AA, I was not really effectively treating alcoholism. Paying attention to AA has been a tremendous help. We recently looked at the treatment records of 240 patients who came through our month-long inpatient treatment setting, and only 6 of our 240 patients were not hooked on other medications. It appears that our patients had really run the gauntlet of "helpers" who did not understand alcoholism—who actually assisted the progression of the disease. Recent studies in New York State indicated that half of a random sample of 500 general hospital admissions were undiagnosed alcoholics. Other studies indicate that maybe 20 to 30 percent of hospital general admissions are alcoholic admissions. Any way you cut it, we have been better at patching up drunks than treating their primary illness. AA has grown out of our professional reluctance to embrace the primary disease. The future of alcoholism treatment will demand our continued dialogue with self-help groups like Alcoholics Anonymous. □

> "We are as effective with patients who are forced into treatment as we are with the rare persons who by their own accord decide that they need treatment."
>
> —Wenger

From page 17

self-awareness rather than an information-based program, which promotes the philosophy that by developing self-identity, confidence, and decisionmaking skills an adolescent's ability to make proper decisions for himself or herself will be greatly enhanced).

Through the initiative of the Little House Drug and Alcohol Program in Dorchester, Massachusetts, (which provides both treatment and prevention services), three separate parents groups have been formed. Little House initially worked with parents through PTAs. With planning input from parents on the PTAs' drug and alcohol advisory boards, three parent awareness nights were held. The three self-help parents groups were formed from this activity. Notably, Little House is now training parents and school faculty to take over the in-school drug education program in both private and public schools.

In addition to community linkages, some parent groups have established relationships with drug and alcohol program efforts at the State level. According to the Associates Consultants report, these relationships are quite varied. A statewide network of parent groups exists in Florida, supported by Single State Agency (SSA) funds. There is a statewide network for all types of prevention programs in Nebraska supported by the SSA, which is proposing to fund a statewide technical assistance effort for parent groups that could lead to a special statewide network of such groups. There have been discussions in Massachusetts at both the SSA and parent group levels of forming such a parent group network in the State.

Issues To Be Resolved

Just as there is no uniform pattern to parent group activities, there is no uniform pattern in their system relationships. Some groups are involved extensively not only with traditional treatment and prevention programs at both the community and statewide levels but also with a host of other service agencies and organizations. Other groups operate with almost no interaction with other prevention activities. According to the report, the movement as a whole is not yet part of the prevention mainstream. While numerous parent groups have well-established relationships with other prevention providers, and work with the SSAs, this is not true of all groups.

Kinard comments that "we really need to look at resolving some issues. First, we parents need to be treated with some respect. Professionals have to understand how we feel about terms such as 'responsible use' and 'experimenter.' Use of such terms lets parents stay apathetic and become enablers. There is no room for 'responsible use' when what we're talking about is *illegal* use. If children are told they can learn to use drugs responsibly, they're being given a message to break the law. Treatment and prevention professionals have to come to understand this and to work with us on it. There is room for terms like 'experimenter' in treatment, but not in prevention. Again, its use allows parents to remain apathetic, and often they don't intervene until their kids have serious problems.

"Professionals need to understand the type of hurt we have and realize that these terms trigger this hurt. We're only human. We're trying to save our kids' lives. I would recommend three things: first, that the literature be updated; second, that we eliminate use of such terms; and third, that professionals be made to realize that we don't want their jobs. We can become the greatest lobbying group in the world for prevention if we behave in a calm, reasonable manner, but we can act this way only if we are treated with respect, as intelligent human beings."

Barton is optimistic about continued progress in developing mutually supportive relationships with alcohol and drug programs. "What everyone has to understand is that the parents' movement is a relatively new phenomenon. Professionals have been working in their field for years and years, and we're the new kid on the block. As usually happens in a situation like this, the more established groups feel threatened; in this case it's related to the fact that we as parents can accomplish some things that the professionals simply cannot. This is by no means a criticism of professionals. The vast majority of them have welcomed us. The parents movement has grown dramatically since its inception, and with this growth has come professionals' recognition that we're reasonable people who are working towards the same goals as they are—that we're attempting to achieve something in a (and I use this word with caution) *professional* manner. I know that throughout the country parents are working closely with professionals, particularly in the mental health and alcohol and drug abuse fields. More specific to alcohol, Parents Who Care in California has such a relationship."

Kinard suggests that the changing funding scene is one factor that should strengthen coopera-

tive linkages. "We realize that there is not enough money, time, or personnel to do all the work that has to be done. There is not enough government money for prevention programs right now. We can be volunteers in getting money from the corporate sector. We're willing to take up the slack where needed. For example, we have made the offer to the Colorado State Department of Education to do all the work necessary to get out accurate alcohol and drug information to all the schools. We would do all the research necessary and pay for the literature and the postage. We can get money; what we're asking the professionals for is some help and guidance.

Future Directions

Professionals in both the alcohol and drug fields are looking with interest to the potential parent groups' offer as a prevention resource. The Associates Consultants report notes that parent action groups have demonstrated a tremendous capacity for increasing community awareness—indeed, for creating environments that are more conducive to the development and implementation of all manner of primary and secondary prevention programs. Moreover, many of these groups have proved to be effective catalysts for securing total community participation in the drug prevention effort.

Charles L. Durban, M.Ed., of Eagleville (Pennsylvania) Hospital and Rehabilitation Center suggests that the impact of alcoholism prevention programs can be expanded if alcoholism professionals work closely with parent action groups. "The infusion of these parent groups into prevention work has enabled us to stretch our resources, more actively promote drug and alcohol abuse education programs, and find political support for our efforts," says Durban, who has helped to develop eight parent action groups in Montgomery County (Pennsylvania), population 700,000. "For these reasons, seeing parent action groups as responsive community organizations rather than as a vigilante threat can be a positive way to enhance our own ability to decrease drug and alcohol abuse."

Kinard comments that parent groups are interested in the alcohol issue. "Our organization has dealt with alcohol and drugs as one problem from the very beginning. It would be a waste of time for us to just talk about marijuana. Alcohol is an illegal drug for children, it's a narcotic drug just like the rest, and it's damaging. Unfortunately, most parents won't come to a talk that's just about alcohol, so I have often gotten through the back door on this subject by talking about marijuana. They'll come hear me talk about that, and once I've got them in there, I'll start talking about alcohol too.

"I tell parents to examine themselves as role models in the home. For instance, the parent who comes home from work and says 'I need a drink' is putting out a 'do drugs' message. If you're out mowing the lawn on a hot day and come in and have a beer because it's nice and cold, that's a different message you're giving your kids.

"I tell parents things about alcohol that they have to hear, and that they might not hear from professionals. I don't separate alcohol from other drugs. I tell them the medical facts about alcohol use. A lot of them don't want to hear that drinking can be as bad for their kids as using other drugs."

Barton agrees that, while it may be more difficult to get parents to support efforts in preventing alcohol use than drug use, many parent groups intend to focus on this area of concern. "We are concerned that many parents don't understand that alcohol is a drug, and that it is just as devastating as other substances. Many of them say, "Thank God, my child is only drinking."

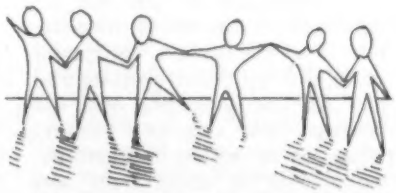
"Our group is addressing the alcohol issue continuously by taking positive steps to place more emphasis on the concept that alcohol *is* a drug. We want parents to see it has a severe, lasting effect on their children." According to Kinard, alcohol professionals are partially responsible for the mixed message society has about youthful drinking. "We *want* to work with the alcohol people," she explains. "They have a lot of good information. But they also have a lot of *bad* information. The people who are the leading sources of information about alcoholism are spreading the 'responsible use' and 'it's okay to experiment' message throughout the country," she notes.

Kinard concludes that parent action groups are "going to do a lot for alcohol prevention, because we're hitting on the subject again and again in our talks before parents groups. In one community, a group of parents took out a full page ad in the major newspaper announcing, 'We will be having parties for our children and we promise that no alcohol will be present at these gatherings.' They all signed their names, and they went one step further by stating the law: it is illegal for minors to drink and anyone who furnishes liquor or a place for drinking is liable.

They put it in the paper for everyone to see, saying 'We're going to file against you if you do things like that.' They paid for that ad out of their own pockets."

Activities such as these have lent momentum to parent action groups, allowing them to accomplish a great deal, say most observers. According to the Associates Consultants report, observational evidence indicates that many parent group activities are effective and are having an impact on youthful drug abuse and on parent effectiveness in coping with that drug abuse. Since the types of primary prevention activities undertaken by most parent groups are most effective with younger children—pre-high school, and those youth who have not yet become heavily involved with drugs—many parent group advocates contend that the real effectiveness and impact of their activities will not be evidenced for 2 or 3 years. When these younger students reach high school age, they say, there should be a measurable decline in drinking and drug-taking behavior. □

—Jill Vejnoska
Staff writer



"There is a not so quiet revolution taking place in America. In striking contrast to the bureaucratization and professionalization characteristic of our society, people are coming together in small groups to overcome handicaps or solve mutual problems. The growth of these self-help groups has been phenomenal. It is estimated that there are three-quarters of a million self-help groups in the United States with a total membership of over 15 million."

"Some of the values long dominant in American culture also provide support for the self-help movement. Pragmatism and a skepticism of those with formal educations rather than life experience are but two examples. The values of individualism and self-sufficiency that are so prominent in American folk tales are also quite consistent with self-help."

From What Is Self-Help? by Stuart Langton and James Petersen, Citizen Participation *3(3): 1982*

"The following are some suggestions for training professionals to work with self-help groups:

- Have professionals attend open meetings of existing self-help groups, particularly AA and Recovery, Inc., and also chapters of groups that they might be helping to form.
- Simulate self-help groups in the training process.
- Have some sessions in the training process include members of self-help groups, films of self-help groups, or presentations by members of self-help groups.
- Have discussions of the 'self-help way' in contrast to the professional way, and directed toward raising consciousness and away from the need to control the group.
- Present case histories of professionals working with self-help groups, with particular emphasis on various critical decision points, e.g., entry, developing a contract, disengaging, dealing with a group that is 'stuck.'
- Help the professional to accept that there is a natural, useful tension between self-help groups and the professional.
- Help the professional learn how to spot leadership and to encourage it.
- Conduct most of the training in an experiential fashion with minimal didactic presentation.
- Help the professional to assess the organizational setting in which he/she works and the issues involved in introducing self-help groups in the particular setting—how to overcome resistance and develop strategy.
- Encourage the professional to join a self-help group and to reflect on this participation, as well as to reflect on participation in previous self-help groups of which he/she was a member.
- Review the many ways in which professionals have related to self-help groups

From Training Professionals in Organizing Self-Help Groups by Frances J. Dory and Frank Reissman, *Citizen Participation* 3(3): 1982.

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Sobriety Clubs A Japanese Version of Self-Help for Alcoholics

Self-help groups or "sobriety clubs" that meet in the cities, towns, and villages of Japan have quietly revolutionized alcoholism treatment in the country in the past 14 years, according to Takeo Fukuda, M.D., Director of the Department of Psychiatry at the Matsue Red Cross Hospital in Matsue City, Japan. The groups are patterned after those of Alcoholics Anonymous (AA), yet remain uniquely Japanese, said Fukuda, who spoke at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as part of a research exchange program.

Fukuda founded the first community sobriety society, or Danshukai, in 1967 in Matsue City, the capital of rural Shimane prefecture, 1 of 47 geographical areas in Japan. Today there are 52 community clubs with more than 450 members in the 59 cities of the prefecture. According to Fukuda, 88 percent of the cities, towns, and villages in the prefecture have organized their own clubs.

The community sobriety clubs are an outgrowth of hospital-based sobriety clubs developed in Japan in the 1960s. Unlike AA, sobriety club members make their names, addresses, and occupations known to the outside world. "The general public in Japan does not consider alcoholism a sin," Fukuda said.

Although there is no specific reference to a "higher power," as in AA, the clubs emphasize the need for improvement of the self, he said. The clubs are generally organized with cooperation from the medical profession, and family members are expected to take part in the activities.

The emphasis on community and family involvement is new in Japan, Fukuda said. Prior to World War II, treatment for alcoholism was largely confined to hospitals, Fukuda said. A temperance society had been started in 1853, and an abstinence movement—inspired by activities in the U.S.—flourished temporarily but collapsed with the country's defeat in 1945.

In the 1950s, two sobriety societies were combined to form the All Nippon Sobriety Association (ANSA). In the 1960s, physicians began to actively seek better treatment methods as they became frustrated with the ineffectiveness of drug therapy and patient isolation. Physicians then began to collaborate with patients to form hospital-based sobriety clubs.

According to Fukuda, however, the hospital-based clubs had certain limitations. "If we trusted too much to this method, the patient would rely too much on the doctor and would eventually lose the desire for self-help approaches," he said. "Moreover, there would be strong resistance to attending meetings held in a mental hospital."

Fukuda started the first community-based club with the assistance of staff in three mental hospitals in Matsue City. Since then, the Shimane method of treatment has been adopted by the ANSA as its fundamental policy. Today, ANSA is composed of 293 clubs and 42,000 members throughout Japan.

Fukuda studied 110 of his patients for 5 years as part of an effort to evaluate the Shimane approach. Most of the patients were 40 to 49 years old, and 89 percent had a clinical history of previous physical or mental problems. Sixty-three patients lived outside the hospital and came in periodically for treatment; 47 had been hospitalized for 3 months, and all 110 were advised to join sobriety clubs. Of the 54 who chose to rely solely on medical treatment in the hospital, only 1 remained sober. However, 27 of 56 patients (48.2 percent) who joined the clubs and continued to attend meetings have abstained from drinking (after 5 years), Fukuda said.

"I can say that the most effective method of treating and preventing alcoholism is not only to treat the patients within the hospital bounds, but also to attach more importance to the role of community clubs, where they can continue to attend the club meetings even after their treatment," he said. "I think one of the reasons for the high average is that in Shimane there are clubs in almost all cities, towns, and villages, and if the members wish, they can attend the meetings almost every night. I firmly believe that the prospect of a bright future in the treatment of alcoholics will be obtained from the nationwide development of our Shimane style approach," he added.

For further information, contact Takeo Fukuda, M.D., Director, Department of Psychiatry, Matsue Red Cross Hospital, Matsue City, Japan.

—Nancy Johnson

AA Membership Reinforces Therapeutic Goals, Says Study

Greater purpose in life, internal locus of control, and expectations of a successful outcome in treatment are primary factors in the success of traditional treatment for alcoholics, says Vincent J. Giannetti, Ph.D., Duquesne University School of Pharmacy. Does membership in a group like AA, which has generally been recognized as a successful adjunct or alternative to traditional treatment, make a positive difference in such variables?

The answer seems to be yes, according to findings from a study of 130 persons, 95 AA members and 35 nonmembers. Reported in *The American Journal of Drug and Alcohol Abuse* (Vol. 8, No. 3, 1981), the study indicated that AA members can be differentiated from nonmembers "along lines consistent with therapeutic goals in intervention of problem drinking." Many of the variables translate into attitudes that con-

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sistently yield positive therapeutic results: less anxiety means a greater purpose in life, which leads to a greater degree of self-actualization and integration of psychosocial experiences. Internal locus of control can lead to a sense of increased mastery and responsibility for managing one's life. Envisioning a successful outcome to treatment is important in determining how much one will invest in and be committed to the therapeutic goals and tasks.

"While AA may not be the cure for alcoholism, the encouragement of these attitudes in the recovering alcoholic via the spiritual-inspirational framework may account for the success of AA as an adjunct to or substitute for traditional therapy," said Giannetti. "Certainly, the attitudes that AA encourages for its members would be consistent with the general goals of psychotherapy intervention and thus AA membership could be an important adjunct and reinforcement for more traditional treatment."

—*Millree Williams*

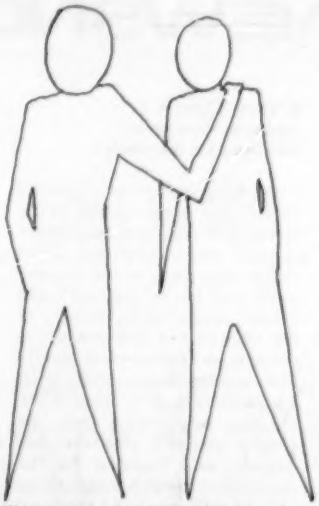
Self-Help Group Involvement Part of Treatment Process

Two California social model alcoholism programs, Pathfinders and CLARE (Community Living for Alcoholics by Rehabilitation), use volunteers extensively to supplement paid staff. The 'We Care Bunch' is the volunteer group at Pathfinders' Neighborhood Recovery Center (NRC). Service seekers are encouraged to join the 'We Care Bunch' relatively early in their recovery programs. Volunteering to help one's peers and the program is regarded as a vital part of the individual's recovery. The volunteers answer phones, give presentations, transport sick alcoholics to detoxification centers, and help service seekers in the NRC.

The volunteer contribution is critical not only to the philosophy of recovery but also to the actual operations of Pathfinders and CLARE. The 'We Care Bunch,' and volunteer staff members contribute about 30 percent of all personnel time at Pathfinder's NRC. In addition, an uncountable number of hours are contributed in both organizations by service seekers, alumni, and other volunteers.

—From an article by Thomasina Borkman in *Citizen Participation*, 3(3) 1982.

"Much of today's self-help volunteerism has emerged as a direct reaction to people's growing sense of alienation. Inflation has sapped consumers' buying power in the marketplace, so they have shifted to nonmarket activities. Professionalization has made it difficult for citizens to influence the quality of social services and medical care, so they have organized to provide some of their own care. Management hierarchies have proved increasingly inefficient, so many corporations and unions now look toward cooperative means of improving productivity and the quality of work life."
From Leadership in Self-Help/ Mutual Aid Groups by Leonard D. Borman, Citizen Participation 3(3): 1982.



"Yet it is precisely these other mechanisms—outside the conventional professional's control—that are so helpful in self-help groups: *instant identity*—finding someone else who shares your condition so you do not feel so alone; *altruism*—reaching out to help someone who is going through an experience similar to your own; *networking*—becoming part of a quasi-extended family that is accessible upon call; *acquiring wisdoms*—these are specific teachings or ideologies that apply specifically to persons with a shared concern; *sharing information*—tapping the range of understandings and experiences that members of the group have acquired as they cope with particular problems. Through all of these mechanisms—clearly distinct from those employed by professionals—participants derive a positive, upbeat, inspiring sense in dealing with pressing conditions and issues."
From Leadership in Self Help/ Mutual Aid groups by Leonard D. Borman, *Citizen Participation* 3(3) 1982.

Blacks And Alcoholism: Issues In The 1980s

Millree Williams

There is considerable evidence that alcohol problems have a major impact on black Americans. The violent consequences of alcohol abuse have been extreme for black Americans (especially black males) in terms of homicides, accidents, criminal assaults, and other conflicts with the law (NIAAA 1978). In addition, black Americans suffer disproportionately from the health consequences of alcoholism, including cancer, obstructive pulmonary disease, severe malnutrition, intestinal disaccharidase actions, hypertension, and birth defects. The rate of hypertension, higher among blacks than any other group, is further complicated by drinking, according to the Fourth Special Report to the U.S. Congress on Alcohol and Health (NIAAA 1981). It also points out that although cirrhosis mortality rates have generally declined each year since peaking in 1973, they are still disproportionately high among black Americans. In some cities, rates among black males aged 25 to 34 are as much as 10 times higher than for white males of the same age. Overall, the cirrhosis mortality rate for black Americans is nearly twice that of white Americans.

King (in press) suggests that in 1980 alcohol abuse remained "the number one health problem

in the black community." He reports that the picture has not improved since 1976 and that no real breakthrough is in sight, either at the level of national social commitment or definitive social science activity. In regard to the severe social consequences of alcoholism in the black community, an NIAAA report (1978) notes that "some researchers attribute the apparently disproportionate devastation caused by alcoholism in the black community to the widespread 'ghettoization' and victimization of blacks in the United States."

Compounding the situation is the fact that blacks are proportionately underrepresented in the service delivery system, both as clients and as caregivers. Black alcoholics and problem drinkers are unlikely to seek out traditional treatment programs unless there is a crisis or mandatory need, such as life-threatening illness, threat of job termination, or referral by the court or social service agency, according to those in alcoholism treatment settings.

In addition, there has been little recent activity in the research area regarding etiological factors and the social and biomedical consequences of alcoholism unique to the black American. Evidence indicates that drinking patterns among blacks differ from those of whites, and that incidence patterns also differ. But little further research has been conducted in the past 5 years.

At an NIAAA-sponsored workshop held in Jackson, Mississippi, in the summer of 1981, more than 25 black alcoholism program administrators, educators, and researchers convened to discuss these and other alcohol-related issues facing the black community in the 1980s. Abraham Kidane, California State University, pointed out that in the 1960s and early 1970s there was a gradual improvement in the socioeconomic conditions affecting blacks, with the enactment of the Civil Rights bill (1964) and equal employment opportunity legislation (1972), and the implementation of numerous income maintenance programs. Kidane said that "in the 1970s, we seemed to have lost our momentum in areas of employment and relative income. During the 1974 recession, blacks lost their jobs at double the rate experienced by whites, and as recovery got underway they were called back at a slower rate. Between 1975 and 1978, unemployment remained almost unchanged. In 1969, only 5 percent of all black women in the labor force and who were heads of families were unemployed; by 1978, the unemployment rate among this group was up to 15.4 percent.

Kidane linked fluctuations in the economy to the rate of alcohol problems in the black community, noting that blacks are proportionately more severely affected by economic downturns. Increases in the unemployment rate, he observed, "have the most significant impact. . .on stress variables." These variables—such as suicide rates, State mental hospital and prison admissions, homicide, cirrhosis of the liver, cardiovascular and renal diseases, and mortality—can be correlated with factors like the unemployment rate, he said.

Kidane and other workshop participants agreed that alcohol-related problems among blacks continue to be a major problem, and that resources are inadequate to successfully prevent and treat the problem. There was wide-ranging discussion of the unique differences—historical and cultural—that characterize alcohol problems among blacks, and the need for research, prevention, and treatment that recognizes the special needs of the black alcoholic.

Research Findings

Many of the workshop participants echoed Kidane's emphasis, suggesting that social and cultural factors have a greater impact on both the etiology and the treatment of alcohol problems among blacks than is the case among other groups.

"Successful role performance in the black community can rarely be understood in the absence of factoring into one's analysis the direct relationship between socioeconomic forces that most often negatively impact the black communities and the resultant intrapsychic processes of its residents," said Dr. Creigs Beverly of Atlanta University School of Social Work. He asserted that a psychosocial model of alcoholism in fact "blames the victim" for social dysfunctioning, and suggested there is "greater promise" in fighting substance abuse in the black community by applying a "sociopsycho model," that is, examining how socioeconomic conditions impact intrapsychic (internal mental) processes.

Dr. R.A. Winbush of Vanderbilt University suggested that race and racism are important intervening variables in alcoholism among blacks but noted a lack of research dealing with such variables. In an analysis of reviewed literature on black alcoholism for a 30-year period (1939-1969) done by Harper and Dawkins (1976), only 77 of 16,000 studies dealt with blacks. And of the 77 studies, 66 compared blacks with whites; only 11 examined blacks only. Winbush also observed that researchers prefer comparative studies over longitudinal studies. "Virtually no longitudinal studies exist that measure the long-term effects of services provided to

participants of treatment programs," he noted.

Winbush suggested that this paucity of research is damaging, in that there exists little empirical support for the need for treatment programs tailored to special needs of blacks. He suggested that one area of research for the 1980s should address reasons why blacks do not use existing alcoholism service programs. "Even though attrition rates are one of the most vexing problems facing alcoholism service programs, little research exists that precisely identifies factors that contribute to the high dropout rate of blacks in such programs," says Winbush.

Research, the group agreed, is essential if blacks are to be more effectively served by alcoholism programs. There was also consensus that one way to encourage such research is to encourage historically black colleges to develop strong research training programs. According to Winbush, black colleges should strengthen curricular efforts in two areas: a service delivery curriculum for students interested in counseling and treatment of black alcoholics, and a research track to train black students interested in developing sound data on black alcoholism. Winbush added that "equal numbers of students should be recruited for both tracks, and the program should emphasize

Alcoholism And Blacks : A Historical Context

The nature of alcohol problems in the black community stems from the unique history of this ethnic group, according to many observers. Likewise, cultural influences play a role in responses to the problem.

Alcohol was initially used as a controlling mechanism by slaveowners. "In America, alcohol was distributed generously to slaves on holidays as a reward for obedience and hard work; slaveowners hoped in this way to combat any movement toward insurrection. The use of alcohol accompanied by drunkenness was considered normal on those occasions" (Davis 1974). Following Nat Turner's revolt in 1830, slaveowners became concerned about drunkenness as a precipitator of slave revolt, and enacted numerous laws placing tighter controls on alcohol use by blacks.

Interestingly, these constraints on blacks continued even after the granting of citizenship in the post-Civil War period. Many argue that their new citizenship did nothing to change the status of blacks during the Reconstruction Period. In search of a better life, blacks moved en masse from small southern rural communities to large northern industrial cities. However, discrimination forced them into slum ghettos; many were unemployed with no marketable skills; and the family structure was disrupted, indeed destroyed, as black men were forced to leave home to find work. Davis (1974) suggests that for some individuals drinking became a means of coping with this dramatic change in environment.

Workshop participants agreed that despite these and other major disadvantages, both historic and current, the black community has traditionally been resilient and able to derive positives from seemingly implausible situations. "The very word JAZZ. . .describes a lifestyle that blacks themselves created in juxtaposition to the physical brutality of sharecropping and the spiritual bleakness of a missionary version of Christianity that was carried throughout the South by Yankee descendants of the Puritans," says Paul Bontemps. Creigs Beverly echoed the same feeling when he commented that, "though subject to extremely oppressive conditions, black people have never resigned themselves to a life of voluntary servitude, and American history is replete with evidence of their continued protracted struggle against those who would deny them access to the fullness of their humanity."

—Millree Williams

career opportunities for each curriculum. There was consensus that greater support for such programming should be sought from both the public and the private sectors.

Application of Research to Treatment

Research, no matter its intent, has no value unless it is applied to real-life situations. According to the workshop participants, black alcoholism professionals and those researching alcohol-related data in the black community must find ways of developing stronger partnerships. Just as research must not be divorced from the realities of the program setting, prevention and treatment programs must attend to the need to document their effectiveness through evaluation research. Bertha Holliday, of George Peabody College, pointed out that planners should make prevention outcomes more practical and quantifiable to the extent that they represent indicators of reductions in the negative behavioral consequences of drinking. According to Holliday, this approach should result in more powerful documentation of program effectiveness, which, in turn, would be more amenable to the tight cost-benefit analyses of the '80s. According to Holliday, a pragmatic approach dictates that greater emphasis must be placed on three issues:

- Conceptions of problems and issues
- Role of research
- Selection of program evaluation criteria

As this translates into strategies for black alcohol prevention efforts, it means taking sociocultural and developmental consideration into account when conceptualizing alcohol-related behaviors and their prevention, developing research-based approaches to service provision, and incorporating program evaluation criteria that emphasize indicators of reductions in the negative behavioral consequences of drinking.

Treatment Approaches

Workshop participants voiced support for continuing efforts to refine counseling approaches that are "culture specific." Erma Wright of A.L. Nellum and Associates in Atlanta noted that counseling from a cultural perspective has existed since the beginning of counseling. It basically involves understanding the client's frame of reference and incorporating it into therapeutic strategies to maximize their effectiveness. Most of the major therapeutic philosophies are based in the cultural context of the majority of the clients seen by the particular theorist. For example, Freud would not have been successful had he not based his concepts of human behavior on young Viennese women, his primary clients. But would Freud have been successful in psychoanalyzing an African native woman? Most likely no more so than an African witch doctor would be in shouting to a young Viennese woman, even though both the African and Viennese women may manifest the same symptoms. It's the approach that tells the tale.

Conventional alcoholism counseling in this country, not surprisingly, is based in the culture of the majority of clients—white males. Such an approach is not always responsive to the black client's mores and value system. Wright suggested that there is a very basic link between culture and counseling. "If cultures are characterized by their behaviors and learned problem-solving techniques, and if counseling is a process to help the client engage in these very things, it would seem that the two concepts are intrinsically linked," said Wright. "Any discussion of alcoholism treatment and counseling approaches as they relate to blacks must take place in the context of the minority culture—its history, strengths, values, attitudes, and culturally specific treatment approaches."

Wright suggested that, as programs are asked to do more with less, one approach should be to emphasize cultural relevance, in order to maximize program utilization by the primary target group and ensure that existing services are as effective as possible. For programs designed to serve blacks, this means instilling in counselors an awareness that the alcoholism among clients is not problematic, but symptomatic. To address this, according to Wright, counselors must adopt nontraditional roles, i.e., become social change agents. Counselors must work with clients to change the socioeconomic structure that gives rise to some of the problems associated with black clients' poverty, unemployment, poor housing, and poor nutritional habits. "The social change agent role represents a better and more productive use of resources of counselors than a palliative effort to patch up the mistakes of the past without preventing the mistakes from recurring," said Wright.

Wright suggested that counseling from a cultural perspective should incorporate cultural rapport-building actions, including developing treatment strategies and counseling techniques that take into account cultural perspectives about eye contact, touching, time, language, social distance, and other patterns of behavior and communication styles. In addition, a holistic approach should be taken in seeking to understand the black

client in the context of family, community, and origin.

Reaching Black Alcoholics

Employee Assistance Programs (EAPs) have been highly successful in reaching problem drinkers early in the development of alcoholism. Because early intervention is particularly difficult to accomplish with the black alcoholic, do EAPs offer hope? As with community-based counseling programs, black clients referred by EAPs seem to be underrepresented.

William Rosemon of the Texas AFL-CIO Workers Assistance Program pointed out his experience with black unionists, who constitute approximately 17 percent (2.5 million) of the Nation's 13.9 million members. He suggested that blacks generally do not get involved in the politics of labor movements. A major step toward bringing in programs that are sensitive to their concerns would be to increase black participation in union politics, according to Rosemon.

In addition to black inactivity in the political process, Rosemon suggested that there are several other reasons for black unionists' underutilization of treatment services:

- Inability to absorb costs when not included in insurance coverage
- Few black service providers on EAP staffs
- Programs oriented to white middle class
- Few blacks on policy-making committees for EAPs

William Davis of the Little Rock, Arkansas, Office of Alcohol and Drug Abuse Prevention suggested that, with particular regard to black-owned businesses and businesses with a large black employee pool, many of the employers are not as knowledgeable about the advantages of EAPs for their employees as they should be. "It is imperative that employers begin to look at what makes their employees tick." He suggested that strategies be developed that get employers to look not only at employee performance but at "other significant factors, such as cultural or racial problems that may be operating that will definitely affect that employee's performance." To effectively work with a large black constituency within the labor force and to strengthen, increase, and maintain employee productivity and relations, Davis feels that white and nonwhite employers should consider setting up culturally relevant programs in the company to increase understanding of the following: black culture and its effect on the black psyche and job performance; interactions between supervisors and employee, especially the white supervisor and black employee; significant problems that often face black employers and employees and the role of industry in helping employees deal with them; and the manifestations of external stress on the black male.

Reaching black alcoholics in rural areas is a particularly difficult problem. In urban areas, prevention treatment and services are available, but underutilized. However, many blacks still live in very rural settings, and the problem of underutilization is compounded because facilities are scarce and less accessible, and drinking patterns have not been documented. The conspicuous absence of documentation concerning alcoholism among rural blacks was a major concern of the conference participants. Some pointed out that one reason for the paucity of research is that alcoholism among rural blacks has no significant social or commercial impact.

Is Alcoholics Anonymous (AA) a viable treatment alternative for blacks? Although blacks have been generally underrepresented in AA, the combination of fewer dollars for programs and increased scrutiny of program effectiveness is forcing blacks to take a longer, harder look at alternatives. Like mainstream treatment programs, AA was founded and traditionally has served primarily the middle-class white male. However, Fulton Caldwell of NIAAA pointed out that there is nothing intrinsically discriminating about AA, and that there are several aspects that, when scrutinized, should be very attractive to blacks fighting alcoholism. According to Caldwell, unlike the analytic mode used in some treatment programs, the focus of AA is on the experiential mode of inquiry. By focusing on the individual's experience with alcohol, AA attempts to validate a person's knowledge via experience. In addition, the essential elements of AA philosophy—sharing of common experiences, mutual acceptance of one another as human beings, and trusting a "higher power"—are all strong elements in the black frame of reference. AA describes itself as a "loose federation of somewhat diverse groups whose unity lies in their primary purpose to achieve sobriety, but whose culture, format, values, composition, and language usage may be quite varied." According to Caldwell, there are AA groups that are predominately black, gay, women only, men only, physicians, lawyers, airline pilots, and numerous other subgroups. The one thing that they all have in common is that they are single-minded in pursuing sobriety.

Caldwell suggested that black-oriented treatment programs should consider working more closely with AA. "Since AA has been the most effective program in achieving sobriety, and is the

most economical (free), then a very useful resource is being underutilized by a significant portion of the alcoholic population," says Caldwell. AA offers many advantages, Caldwell noted, in that it provides ready access to the AA fellowship, it facilitates a strong followup contact in the aftercare program, it provides a wide variety of sober role models for newer clients undergoing outpatient treatment, and it serves as a "bridging" group to the community for clients undergoing inpatient treatment.

Prevention Approaches

No major disease has ever been eradicated without a broad-based approach incorporating both treatment and prevention. Reaching today's black youth is the key to the solution of tomorrow's alcohol abuse and alcoholism problems in the black community. According to Valetta Miranda of the National Clearinghouse for Alcohol Information, most of today's prevention efforts are geared to youths aged 5 to 18, with a special focus on those in grades K-6. It is during this period when they "are still gathering information that later will be the foundations for attitudes and behaviors," says Miranda. "Many successful youth prevention programs have developed strategies to change the behavior and attitudes necessary to lessen the incidence of alcohol-related problems," she commented. "Such strategies attempt to help youth in looking beyond their present situation and to help them focus on the broader issues of life," says Miranda.

Miranda outlined two strategies for prevention efforts: alcohol-specific and nonspecific strategies. Alcohol-specific strategies address the problem of alcohol abuse directly by trying to influence what people drink and how much, how often, when, why, and where. These strategies have included alcohol education in the schools, peer alcohol educator programs, public awareness campaigns, DWI prevention activities, and even training of bartenders to expand their helping role as listeners and referral sources for all types of problems. Nonspecific strategies are designed to affect alcoholism and drinking behavior indirectly, dealing not with alcohol but with the broader aspects of life, such as alternatives to drinking and facilitating interpersonal relationships. Many of these activities revolve around values clarification, decisionmaking and coping skills development, assertiveness training, vocational training and job-finding skills, nonjudgmental interaction between youths and adults, and alternatives for relaxation, such as sports, recreation, and yoga. The more recent comprehensive approaches to alcohol abuse prevention attempt to incorporate both types of strategies to maximize effectiveness. According to Miranda, there are three major program concepts or models developed with NIAAA funding currently being used in different variations across the country.

- *Model 1*, being tested in King County, Washington, tries to promote positive self-image as a deterrent to alcohol abuse by training teachers to conduct open-ended education sessions in grades K through 12. The classroom sessions address alcohol information, values clarification, self-esteem, coping skills, and peer pressure.
- *Model 2*, the CASPAR program of Somerville, Massachusetts, encourages interactions between youth and adults to identify a structure for appropriate drinking behavior. The program involves training teachers and school counselors to conduct open-ended alcohol education workshops in grades 3 through 12, training peer leaders to conduct supervised activities among peers and other youngsters, and community outreach and education efforts.
- *Model 3*, at the University of Massachusetts (Amherst), uses the university community to effect overall cultural and community drinking norms at multiple levels: individual, affiliate group, and the entire campus community. The activities range from training dormitory counselors and conducting peer-led workshops to media campaigns and influencing school alcohol policies.

Although they all lend themselves very easily to culture-specificity, the models were not targeted as demonstration projects to minorities.

Because so little research has been done on prevention for black youth, many of the exercises, models, and strategies were developed by professionals who have worked with youth, have backgrounds in black history, or are experienced in the social problems and issues facing the black community today. Many of these professionals have suggested that future prevention efforts geared toward black youth emphasize the importance of black history and culture, build positive self-concepts, emphasize survival skills, demonstrate sensitivity to the special issue of adolescence, and provide a balance between specific and nonspecific strategies.

[1]Single copies of the *Guidebook* are available from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

The NIAAA's Clearinghouse, said Miranda, has been working to stimulate interest in prevention programming among black churches. As part of this effort, a *Guidebook for Planning Alcohol Prevention Programs with Black Youth* has been developed as a resource for managers planning prevention services for black youth.[1] The *Guidebook* encourages the use of community support groups in the prevention effort, based on the belief that the indigenous helping groups in the black community are an untapped prevention resource. Church organizations, for example, have always been a stable force in the community and responsive to the needs of black youth, says Miranda.

Expanding the Resource Base

Dr. Lois Chatham, acting associate director for Program Operations of NIAAA, discussed the shift from categorical to block grant funding, reporting that the Administrator believes the block grant approach will "permit individual States to assume a larger role in assessing their own health needs and in establishing the priorities that will enable them to meet these needs most effectively." According to Chatham, the Administrator also indicated that the new format will give State and local health authorities "the flexibility to respond to new and changing conditions. . .to adjust their programs to local conditions to a greater degree than nationwide requirements have permitted in the past." Chatham said that this new flexibility should offer greater efficiency and cost effectiveness by eliminating duplication among programs, and should maximize the impact of Federal dollars by allowing the Federal money to be combined with existing State appropriations to further statewide goals. Chatham suggested that alcoholism programs will have to begin to consider alterna-

ADAMHA Seeks To Support Research At Historically Black Colleges

The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) is seeking to support research and research training at historically black colleges and universities, in keeping with an executive order from the President that requires Federal departments and agencies to increase the participation of black institutions in Federal programs and resources.

ADAMHA has established a research workgroup, including researchers from the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Institute of Mental Health. The group is expected to recommend ways their Institutes can support increased participation in alcoholism, drug abuse, and mental health research by historically black educational institutions.

In addition, ADAMHA earlier this year sponsored a conference in Atlanta, Georgia, with participants from more than 100 historically black colleges and universities, to discuss research activities and opportunities.

ADAMHA staff discussed the agency's research priorities. Although priorities among the three Institutes vary, all emphasize prevention research as a major initiative, participants were told.

One workshop covered the "nuts and bolts" of research design and proposal development; another offered instruction on developing and implementing research and research training projects; and yet another discussed opportunities in research for black scientists.

James Lawrence, Acting Deputy Administrator of ADAMHA, said the agency will provide historically black colleges and universities with technical assistance, reviewing research proposals and drafts, and making site visits upon request. "We hope to work with historically black colleges and universities more intensively in the biomedical and behavioral areas," added Betty Cleckley, Ph.D., Director of the ADAMHA Black College Initiative.

For more information, contact Betty Cleckley, ADAMHA, Rm. 13C-26, 5600 Fishers Lane, Rockville, MD 20857.

tive funding resources, and that this will require that program priorities are clear and the case for funding these priorities is strongly made. Establishing a consensus on general aims and setting priorities in the area of alcoholism among blacks, she said, is an important first step for programs seeking to serve the black community in making the block grant approach work.

Working with State government. John Bland, of the Maryland Alcoholism Control Administration, noted that it is important for black providers to develop close working relationships with State governments. Black-oriented programs are relatively new to the alcoholism field, he observed; most have been established in the past 10 years, and most have been funded primarily by the Federal Government and consequently have not established strong ties to the State in which they operate.

Bland commented, "I believe that the agenda for black alcoholism programs today is to survive. Working with the State government, including both executive and legislative branches, is now and increasingly will prove to be important strategy to ensure the continuation of black alcoholism programming," he said.

Bland suggested that no plan to secure funds for program operation will be maximally effective unless strategies are developed that nurture relationships with the State Alcoholism Authority, State legislature, State health policymakers, statewide prevention network, and the voluntary sector. Bland suggested that, in seeking a share of State funds, service providers become the "squeaky wheel" in order to "get the grease."

When working with the legislature, one needs to pay particular attention to three areas: self-interest, explicit detail, and time, according to Bland. "Politicians understand very well vested interest." He advised program people not to be embarrassed to directly and openly state their case. In presenting the program's case, managers must pay careful attention to details such as program operation, characteristics of population served, facts, figures, and a thorough, documented understanding of the problem, he said. Program managers must know the answers to numerous questions, such as, What is the target population? How many did you treat last year? Are they staying sober? Are they working? How do your services for them differ from others? How much does it cost, and can you do it more cheaply?

"If you have a black State legislative caucus, determine its general effectiveness. If it has a health committee, cultivate the chairperson," advised Bland, "by determining his or her track record on alcohol issues and, where necessary, raise his or her consciousness of the importance of alcohol issues."

Working with both the State legislature and the SAA, suggested Bland, involves a major time investment, a thorough analysis of the issues, and coordination of numerous local and statewide activities. It is also very important to get black representation and input on any of the State health policy-making boards, says Bland.

Regarding prevention, Bland suggested establishing a network (if one is not already in place) that can distribute informational materials available from the Federal level to secondary schools and colleges and universities. In addition, program managers should investigate the existence of black alcoholism task forces, EAPs in major industries with a large black work force, and the SAA's statewide prevention network.

Local government. According to Bernard Redd, of the Center for Multicultural Awareness in Arlington, Virginia, building networks of professionals and consumers is a big factor in working effectively with local or regional governments and institutions. Understanding the continuum of health care service delivery is very important when working with local governments, said Redd.

"With the passage of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act and the Comprehensive Drug Abuse Prevention, Treatment, and Rehabilitation Act, there was a marked change in national policy from supply reduction (law enforcement, seizure) to demand reduction (treatment, prevention, rehabilitation). Local jurisdictions began to experience the benefits of resources for research demonstration studies and training through a federally planned and coordinated program," said Redd. Yet, because planning guidelines for local agencies were vague, and minority communities were slow in getting involved, early State plans, according to Redd, were not always reflective of minority needs.

These two factors, combined with a lack of data on blacks and alcoholism, placed local planners and managers in the position of developing program strategies that did not always reflect the true needs of the minority communities, said Redd. This contributed to underutilization of treatment, prevention, and rehabilitation services by the target group. Consequently, black programs often have not grown from a community base and program managers must work to establish interdependent relationship with other community service providers. Particularly as public funding de-

creases, programs must guard against the development of competitiveness among health care service providers that "represents the needs of the professionals instead of those of the consumer," he said. Redd also encouraged program managers to "realize the potential use of evaluation as a tool that would be used to improve program design and to influence public opinion and policy makers."

Third-party funding sources. As a third-party funding source, medicaid and medicare should be more fully investigated and exploited, according to Robbie Littles, of the Concerned Alliance for Progressive Action, Inc., in West Palm Beach, Florida. He suggested that program managers serving qualified clients should fully avail themselves of Medicaid benefits. The Federal Government provides matching money to those States providing coverage for alcoholism services in mental health outpatient services, in general hospitals, psychiatric hospitals, and community mental health centers and other conventional services in nonresidential settings. As options, State plans can offer coverage for outpatient services in a psychiatric facility for patients 65 or older; clinic services, including services available in (usually JCAH accredited) mental health clinics; rehabilitation services such as physical or occupational therapy and counseling offered through hospital-administered clinics; drugs; 24-hour nursing care; and home health services. (For those referral services with a high percentage of substance-abusing teenagers, States also have the option to provide coverage for psychiatric inpatient services for those under 21.)

Limited though these services may be, especially regarding alcoholism treatment services, they are still resources and worth exploring. Littles suggested that programs make sure to carefully explore client eligibility.

Private sector funding. Can the private sector replace decreased government-financed programming without jeopardizing quality, availability, and accessibility? Peter Crawford of the Alcohol, Drug Abuse, and Mental Health Administration pointed out three areas in the private (or independent) sector that are of concern to black program managers: private philanthropy (foundations, corporate gifts, voluntary nonprofit organizations, and individual donors), volunteers, and self-help organizations such as AA. The common denominators among these groups are that they are independent, usually nonprofit, and devoted to serving the general welfare.

Foundations, often described as "large bodies of money surrounded by people who want some," disburse large sums of money to selected causes, said Crawford. "Although most Americans are aware of the major foundations—Ford, Rockefeller, Carnegie—they are less aware of the thousands of other foundations, often community or regionally based, that together dwarf the 'name' foundations in total assets," he said. Program managers should note, however, that many of the smaller foundations "reflect the idiosyncracies and passions of the founding donors rather than actual societal needs." Nevertheless, foundations have profoundly altered America for the better through their willingness to fund programs, research, and services on a pioneering basis, said Crawford.

Many businesses offer donations in various fashions, such as establishing foundations, presenting gifts directly to charities and institutions, and encouraging managerial and technical staff to assist nonprofit agencies. With more than $2 billion in contributions in 1979, corporations became the largest single identifiable source of giving in the Nation, he said. A large number of corporations, in addition to fulfilling their economic function of supplying goods at a profit, are increasingly showing sensitivity to the effects of their operation on employees and demonstrating a willingness to serve society, even seeking out ways to do so. It may be a worthwhile exercise for program managers to examine area corporations and businesses vis-a-vis their willingness to provide funding or other support, he said. For example, some businesses may be receptive to an EAP or referral service. Other corporations may be receptive to funding or in some other way providing support for community programs.

Voluntary nonprofit organizations are another potential resource. Groups such as private colleges, the Boy Scouts, the Urban League, CARE, or any of the organizations funded by United Way fall in the category of "charitable or voluntary nonprofit organizations." One characteristic of these groups is that they raise funds and use this income for service delivery, research, or advocacy on behalf of identifiable beneficiaries.

Eighty-five percent of philanthropy in the United States comes from individual donors, particularly those earning less than $20,000 per year. Leaders in philanthropy, said Crawford, believe they have an important role to play in financing health and human services programs, and rest their case on the following points:

- They have freedom from many of the constraints of public funding, in that they can move quickly to serve

a relatively small constituency, are not bound by legislation and regulations, and can afford to fail.
- They have a pluralistic approach that accommodates many points of view and approaches.
- They provide an environment for innovation and creativity.
- They provide support for ideas that have not yet gained a wide public following or acceptance.

Voluntarism is another resource not always tapped by black programs. According to Crawford, approximately 37 million Americans provided the equivalent of $34 billion in volunteered services in 1974. Volunteers serve in schools, hospitals, churches, civic organizations, and action centers, and they collectively reflect "the willingness of many Americans to help others through personal action and service." Despite the changing attitudes, values and lifestyles and energy crises, inflation, and growth of litigation (especially malpractice) that has affected the willingness of some to volunteer, their ranks are still substantial and they represent a rich resource from which to draw.

Self-help organizations represent another resource in the private sector. Most self-help organizations are nonprofit making and experientially oriented, with many characteristics in common.

The most publicized of these is AA. It plays a significant role in meeting the needs of many alcoholism patients, said Crawford. "For example, the *ADM National Data Book*, January 1980, points out that of the 2.4 million persons receiving treatment for alcohol abuse during 1977, 602,000 were treated by federally assisted programs. Of the 1.8 million treated by nonfederally assisted programs and providers, 671,000 were treated by AA," said Crawford.

No overall strategy for mobilizing resources can be complete without considering the many sources of contributions and funding available in the community, according to Ruther Carter of the Broward County, Florida, Alcohol and Drug Abuse Service Division. She suggested developing a plan for mobilizing resources to get agencies, organizations, and groups to increase human and financial assistance—funds, volunteers, equipment, facilities, office space, telephone, and utilities—they can allocate toward ameliorating community problems. In-kind contributions or pooling of material resources with other service programs is a strategy that program managers should carefully examine, she said.

Future Directions

The tone set during the workshop was clearly indicative of the attendees' perceptions of the months, perhaps years, to come: lean, hardworking, purposeful, and intense. There was a sense that professionals must be committed to more than just maintaining the status quo. Indeed, programs will have to become more effective, more efficient, and do more with less.

At the conclusion of the 3-day workshop, Caldwell commended the group of participants for their "realistic appraisal" of the current situation and future directions. "We have looked at sources for program continuation other than just the public sector," he noted, "and developed a working dialogue among practitioners and researchers involved in helping blacks with alcohol problems on which we can continue to build in the future."

The sessions culminated in the identification of strategies that can be pursued to address some of the issues raised during the workshop. There was discussion of the need to expand the scope of services of many alcoholism programs in the black community to include both alcohol and drugs, as well as to develop linkages with other health services. The importance of evaluation and research in supporting program objectives was also stressed.

In mobilizing resources to ensure continuation of programming in the black community, there was an emphasis on the need for development of greater involvement in State legislative activities. In addition, there was discussion of ways black alcoholism programs can develop collaborative efforts with groups seeking to address other problems among blacks.

Working with and seeking to involve traditionally black colleges in training alcoholism researchers and practitioners was also identified as a priority by the workshop participants. Involving more blacks in research, program administration, and policymaking was seen as an important part of efforts to expand and refine alcoholism services in the black community.

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RESEARCH REPORTS

STIARs Available

A series of publications from the National Clearinghouse for Alcohol Information provide translations of selected research articles published in foreign countries. Among the recent articles issued in the STIAR (Selected Translations of International Alcohol Research) series are the following:

- STIAR 62: "Studies on Alcohol Embryopathy," by F. Majewski, translated from German.
- STIAR 65: "Signs of Alcohol Embryopathy Apparent in Childhood," by G. Koranyi and F. Csiky, translated from Hungarian.
- STIAR 73: "Furazolidone —An Alcohol-Sensitizing Drug," by O. Kuznetsov, E. Entin, and O. Kalina, translated from Russian.
- STIAR 79: "The Offspring of Alcoholic Mothers: A Report of 16 Cases of Fetal Alcohol Syndrome," by P. Dehaene, R. Walbaum, M. Titran, C. Samaille-Villette, P. Samaille, G. Crepin, G. Delahousse, J. Decocq, M. Delacroix, F. Caquant, and D. Querleu, translated from French.
- STIAR 81: "The Pathology of Alcoholism," by J.P. von Wartburg, translated from German.
- STIAR 83: "Alcohol—Currently the Most Significant Teratogen," by B. Leiber, translated from German.
- STIAR 84: "Alcohol and Tobacco as Possible Causes of Male Sterility," by F. Stekhun, translated from Russian.
- STIAR 88: "Early Detection and Diagnosis of Alcoholism," by W. Feuerlein, translated from German.

Single copies of STIARs are available, free of charge, from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

—Millree Williams

International Alcohol Research Reviewed

Alcohol research is on the upswing in other countries, and the United States is taking renewed interest in research programs throughout the world, according to Boris Tabakoff, Ph.D., of the University of Illinois Medical Center in Chicago. Observations on developing research programs in the Soviet Union, Scandinavia, England, and Japan were presented by Tabakoff, an internationally renowned traveler and researcher, at a National Institute on Alcohol Abuse and Alcoholism seminar. He is chairman of a newly formed international Society for Biomedical Research In Alcoholism.

"The Soviet Union, in 1980, formed a Commission on Alcohol and Narcotics," Tabakoff said. Although drug abuse was not considered a major problem within the country, alcoholism was, as its prevalence was increasing. The problem caught the attention of political leaders who approved formation of the Commission, which now has two divisions—research and fiscal affairs. An advisory group of scientists is responsible for formation of research policy, Tabakoff said.

Irena Anokhina who currently supervises alcohol research at the All-Union Research Institute of General and Forensic Psychiatry wields considerable power related to her status within the Commission; she also has achieved widespread prominence among colleagues for her own work on the effects of alcohol on the brain, he reported.

As a result, Russian clinicians are moving very quickly to translate some of her recent laboratory findings into useful therapies, Tabakoff said. For example, a major clinical application of her work has been the use of two drugs, apomorphine and naloxone in detoxification.

Naloxone is given early in treatment, in daily doses, to reduce intoxication. Apomorphine is given to reduce the severity of withdrawal symptoms. It apparently stimulates dopamine systems that are depressed with chronic alcohol use. In the United States, naloxone has been tried only on a few patients in comas, Tabakoff observed.

Other Soviet investigators have found that naturally occurring alcohol levels in the body tend to be lower in alcoholic persons. They are now exploring how measurement of these levels might someday aid in prediction of risk for alcoholism, he said.

Prevention in the Soviet Union often includes passing out extensive information in the workplace that warns of the dangers drinking poses to one's health and the health of the unborn child. In general, however, more reliance is placed on the premise that "if you make the punishment heavy enough people will stop drinking," Tabakoff said.

The person caught drunk in public once is assigned to a treatment program. Caught inebriated twice, the person is assigned to a clinic at the work-

place where 3 to 4 months are spent receiving treatment. The person found publicly drunk three times is considered an antisocial personality and can be committed to a psychiatric service on an inpatient basis where therapy may continue as long as 2 years before release, he reported.

Figures on the prevalence of alcohol problems are not routinely released, but with a little ingenuity, approximations are possible, Tabakoff said. For example, about 10,000 persons are treated in Moscow clinics annually. That would be about 0.3 to 0.4 percent of the city's population, he said.

Alcoholics in the country are classified in one of three categories: those who can't control their drinking, those who suffer withdrawal symptoms when drinking stops, and those who have incurred neurological damage. Alcoholism is considered a medical problem, yet the heavy involvement of psychiatrists in treatment precludes much attention to the effects of alcohol on the liver and other organs, he noted.

Therapy ranges from acupuncture to group therapy to private sessions with a psychiatrist. In group therapy, hypnosis may be combined with aversive techniques; group members are hypnotized and a drink is offered, accompanied by suggestion of aversive situations. Disulfiram (Antabuse) implants, slow release capsules implanted beneath the skin, also may be part of therapy. The Soviets are aware that release from the implant is not constant, Tabakoff noted, so they place disulfiram in the food for 3 to 4 months and the patient is told the implant exerts the effect.

The major difference between research in the United States and Soviet Union is the Soviet Union's strong reliance on clinical observation. "It is difficult for them to get the materials and funds to do large scale and controlled clinical trials, so findings often are deduced on the basis of a large number of detailed patient observations," Tabakoff observed.

Scandinavia

In the Scandinavian countries, research received a significant boost recently; a research society has formed to study the biomedical aspects of alcoholism.

In addition, Sweden has allocated $1.5 million this year for the development of three to four research centers, a sizable increase over the previous support, Tabakoff commented. The Swedish Government also is supporting travel by their scientists throughout the world, and in both Finland and Norway, increased amounts of money are being channeled into alcoholism research as well, Tabakoff said.

Much of the Scandinavian research has recently focused on TIQs (tetrahydroisoquinolines), chemical substances formed by combining the neurotransmitters (which carry brain cell messages) and acetaldehyde (the breakdown product of alcohol). It has been speculated that TIQs may cause addiction by acting on opiate receptors as morphine does. The TIQs were suspected to exist in animals. "Now, supposedly, they have been found," said Tabakoff, who called this one of the most exciting recent discoveries. The Scandinavians force-fed alcohol to animals for a long time—250 days, he said, and they claim they have isolated the TIQs in the alcohol-consuming animals and not in nondrinking animals.

The Scandinavians also have developed a test to detect heavy drinkers, based on abnormalities that occur in transferin, a blood protein that binds and transports iron, he reported. The person who consumes four to six drinks daily for a week can be detected with 80 to 90 percent accuracy. The transferin abnormality disappears when the person abstains for 2 weeks. This test could be useful in monitoring binge drinkers, Tabakoff said. Other blood test batteries being developed in the United States, based on routine blood tests, may prove more accurate and useful in the long run, however, he said. (See Research Reports, *AH&RW*, Vol. 6, No. 1, 1981).

Orient

In the Orient, alcohol research in Taiwan is getting underway, but Japan remains the preeminent authority in the field, Tabakoff said. Recent Japanese research has suggested that it is not so much the difference in the speed of acetaldehyde formation as a difference in ability to get rid of acetaldehyde that is the cause of the facial flushing experienced by many Japanese when they drink. About 80 percent of the Japanese break down alcohol to acetaldehyde more rapidly than normal, and this had been hypothesized as the cause of the facial flush.

In another, more recent breakthrough, the Japanese have found that very few alcoholics in their country form high levels of acetaldehyde when drinking, Tabakoff reported. This supports the hypothesis that acetaldehyde is a noxious substance that tends to inhibit drinking; and it casts doubt upon the current speculation that alcoholic drinking is associated with high TIQ levels that are the result of unusually high acetaldehyde levels.

Britain and Australia

In England, a small group of researchers is also concentrating on TIQs, and in addition, they are testing naloxone as are the Soviets. In the British medical journal *Lancet*, several followup studies have suggested it counteracts the depressant effects of alcohol and a few suggested it does not.

Tabakoff reported that he has tested the drug's effect on ethanol anesthetized animals in the United States and has found similar results—some animals are sensitive and others are not. He speculates that genetics may account for the differing response, and advocates more routine use of the drug to treat patients in comas in the United States.

Tabakoff reported briefly on research in Australia, a country that has recently formed a medical society to study alcohol problems. Clinical studies being done in that country use CAT scans to detect drinking-related changes in the brain that may relate to deficits in intellectual functioning. The proteins responsible for breaking down alcohol into simpler substances are also being studied.

—*Nancy Johnson*

Economic Stress Can Lead To Increased Drinking

In small communities that rely on a single industry for their economic well-being, employee layoffs are accompanied by increased alcohol consumption, according to a study reported by Edward Weeks, Ph.D., assistant professor in the School of Community ervices and Public Affairs at the University of Oregon.

Weeks, who spoke at a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) epidemiology seminar, studied several small Oregon towns and found overall community drinking increased significantly when employees were laid off from their jobs in wood products mills. The mills were the major source of employment within the communities. "Other healthier and more diversified communities throughout the country may be experiencing similar effects," Weeks said. "Community economic distress has become a problem of national importance. Plant relocations, business failures, and extended layoffs have become epidemic not only in economically distressed regions but also in regions that are economically healthy," he said.

According to Weeks, layoffs may create new behavior patterns that promote drinking. For example, he said, because the worker is idle, there is more available free time for drinking and socializing. The worker may drink more in the home or frequent taverns with friends more often.

In his study, Weeks hypothesized that economic change causes stress and stress induces drinking. Previous unemployment studies have supported the observation that economic change causes stress and indicated that loss of work disrupts family and social relationships and causes anxiety and depression. Sample surveys have documented decreased self-esteem and increased feelings of powerlessness and helplessness among unemployed workers. Recently, one study indicated that changes in the manufacturing work force in New York State resulted in increased State hospital admissions. Another study found that economic change is strongly related to the occurrence of stressful life events and also to mood; that is, during an economic decline, the incidence of depression is much higher. "So, from a diverse range of research, there is a lot of evidence to say the economy is a generator of stress," Weeks said.

The second part of his hypothesis—that stress induces increased drinking—while often thought to be true, has received less empirical support. Some research indicates that people who feel drinking will relieve stress are motivated to drink, while those who don't think it will help, don't drink. One field survey found that personal life or job stress is most likely to result in increased and more problem-prone alcohol consumption. Another showed that hardships generate anxiety, and some people tend to use alcohol as a temporary escape from unpleasant stress.

One problem with these field studies has been uncertainty as to whether stress leads to increased consumption or vice versa. Also, such studies rely on self-reported data, and many people will not admit to drinking large amounts. Other people experience cognitive dissonance—unconsciously tending to recall their drinking in the way they are most comfortable with so as to reduce anxiety. There is also a possibility that the increased drinking is only a temporary effect, he said.

The current study provides less biased data, however, because alcohol consumption is measured strictly on the basis of sales, and in Oregon all distilled spirits are sold through liquor stores that must report their sales. The small Oregon towns are relatively isolated. Thus, the effects of a mill shutdown are readily apparent and unlikely to be affected by outside factors.

For further information, contact Edward Weeks, Ph.D., Assistant Professor, School of Community Services and Public Affairs, University of Oregon, Eugene, OR 97403.

—*Nancy Johnson*

Measures Of Alcoholism Treatment Outcome

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Many different measures have been used as indicators of treatment success. This review discusses various measures of alcoholism treatment efficacy, in order to assess their appropriateness as indices of therapeutic outcome. Measures of alcohol intake, drinking symptoms and behavioral consequences, psychological adjustment, and social functioning are reviewed in this article with regard both to their relative merit and to their interrelations.

Drinking Behavior

By far the most commonly used measure of treatment outcome is drinking behavior; of the 265 studies of alcoholism treatment examined by Emrick (1974), 80 percent used alcohol consumption as the principal outcome measure. Two measures of alcohol intake have been identified as indicators of treatment success: abstinence and moderate drinking. The former measure may be further subdivided into short-term and long-term abstinence.

Abstinence. Studies of treatment impact often fail to distinguish between short-term abstinence and long-term abstinence. However, recent evidence suggests that these may represent very different treatment outcomes. Polich and associ-

ates (1980) found that short-term abstainers have a different prognosis from that of long-term abstainers. The authors divided people abstaining 18 months after admission into two groups: those currently abstaining but who had been drinking within the past 6 months (short-term abstainers) and those who had abstained for at least 6 months (long-term abstainers). Based on measures at the 4-year followup, long-term abstainers were much less likely than short-term abstainers to develop subsequent drinking symptoms or consequences. The rate of alcohol-related deaths for long-term abstainers was only 1 percent (comparable to the general population); in contrast, the short-term abstinence death rate was 9 percent. Further, short-term abstainers showed a recent history of more severe alcohol problems and higher drinking levels than current drinkers. Finally, short-term abstainers were much more likely to subsequently relapse into alcoholic drinking than were long-term abstainers. The authors concluded that short-term abstention should not be regarded as a form of remission.

It should be noted, however, that complete abstinence characterizes only a minority of patients even when reporting for fairly short intervals (Emrick 1974). Long-term abstinence is even rarer, and the proportion of patients remaining abstinent decreases substantially within the first 2 years (Orford et al. 1976). Only 10 to 15 percent have been found to abstain continuously from initial treatment to a 1- or 2-year followup (Fitzgerald et al. 1971; Gerald and Saenger 1966; Polich et al. 1980).

Drinking symptoms and consequences. A great deal of controversy in the field has centered on abstinence (either long-term or short-term) as the only successful drinking behavior outcome of treatment. At issue here is the question whether or not controlled drinking should be also regarded as a form of remission. Normal drinking has been defined by Polich and associates (1980) as drinking without physical symptoms (tremors, morning drinking, loss of control, blackouts, missed meals, continuous drinking) or behavioral consequences (impaired health, legal problems, fights, missed work). Although a number of studies have published findings of alcoholics who achieve normal drinking (e.g., Armor et al. 1976; Cahalan 1970; Gerard and Saenger 1966; Reinert and Bowen 1968), many researchers are reluctant to accept these results. Current emphasis in the field supports the goal of abstinence. As Baekeland (1977) has noted, classification of clients as moderate drinkers in most "normal drinking" studies was based on a measure taken only once. Long-term longitudinal outcome studies have shown that drinking status for a single individual can vary considerably over time, even when group averages remain the same (Fitzgerald et al. 1971; Franklin et al. 1979; Polich et al. 1980; Wilby and Jones 1962). The Polich and associates (1980) study found that most recovering alcoholics ran a higher risk of relapse if they drank, even in moderate amounts, than if they abstained. However, the survey did isolate certain subgroups of male clients who had a good prognosis if they engaged in "non-problem drinking"—those who were less physically dependent on alcohol and were under 40 years of age at intake.

Problems with drinking indicators. Many difficulties are associated with reliance on drinking behavior—either controlled drinking or abstinence—as the sole criterion of treatment success (cf. Sobell 1978). One problem is that a client may improve on one measure of drinking but not on others. For example, the quantity consumed may have decreased while frequency remained at the same level. Similarly, a pattern of periodic "binge" drinking may have supplanted a previous pattern of continuous drinking. Further, drinking status may be described only for the 30-day period prior to assessment, a period fairly representative of drinking for less chronic abusers but not for chronic alcoholics (Cooper et al. 1980), whose status is better described by a longer 6-month window (Mandell 1979; Polich et al. 1980). Another problem is that consumption measures tend to be unreliable, possibly because of overly precise measurement instruments or patient denial (Baekeland 1977; NIAAA 1979).

Psychosocial Outcome Measures

A further difficulty associated with reliance on drinking indicators is that drinking behavior, in itself, is not an indication of satisfactory life adjustment. Several studies have found a positive relationship between drinking outcomes and outcomes related to psychological status, work adjustment, interpersonal relationships, health status, resolution of legal problems, social stability, and Alcoholics Anonymous (AA) attendance (Bateman and Petersen 1972; Bowen and Androes 1968; Clancy et al. 1967; Emrick 1974; Gillis and Keet 1969). However, many also reported that abstinent alcoholics may function poorly in a number of these other areas (e.g., Gerard and Saenger 1966;

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Moore and Ramseur 1960; Pattison et al. 1969; Pfeffer and Berger 1957; Polich et al. 1980). Thus, while significant correlations have been found between consumption and behavioral impairment (Armor et al. 1976), neither abstinence nor remission of symptoms may be assumed to imply a general improvement in nondrinking domains.

Several studies have used measures of treatment outcomes unrelated to drinking behavior. Improvement following treatment has been demonstrated on measures of psychiatric symtomatology, income, marital stability, employment stability, and mortality rate (Cronkite and Moos 1978; Pattison et al. 1969; Polich et al. 1980). In general, however, the amount of improvement on these indexes tends to be limited (Polich et al. 1980), suggesting that drinking-related measures may more accurately reflect the effects of treatment than do other indexes. That is, the psychosocial measures may be more closely associated with the characteristics of the client and his or her environment than with the treatment he or she receives. If this is the case, the psychosocial indexes would not constitute as fair an indication of the effects of treatment as would the drinking-related measures.

Multiple Indices

The issue of which outcome measure is the best indicator of treatment success is clearly far from resolved. Armor and his colleagues (1976) have offered some support for emphasizing drinking indicators over other measures of treatment outcome. In their words:

> In emphasizing the value of multiple outcome criteria, some researchers have made the error of discounting the relevance of the alcohol consumption criterion. Success has thus been claimed for some therapies on the basis of inferred psychological changes even though the intended objective (i.e., to halt excessive drinking) has not been achieved. An ordering of outcome criteria would seem desirable. Although complete social and psychological recovery of clients is probably the ultimate goal of most treatment programs, the primary objective remains the elimination of excessive alcohol use and the gross signs of behavioral impairment that result from it. It is quite possible that other indicators of treatment outcome (e.g., social adjustment, marital status, income level) are not immediately affected by intervention techniques that reduce consumption level and resultant behavioral impairment (p. 29).

In contrast to this position, many researchers caution against excessive reliance on drinking indicators and advocate multidimensional measurement of treatment success. From the standpoint of validity, the importance of using multiple measures is indicated by findings that vary according to the efficacy measured used. For example, Baekeland and associates (1975) noted that a positive correlation between length of outpatient treatment and success is most likely to appear when outcome is assessed in terms of abstinence. Cronkite and Moos (1978) found that client characteristics were more predictive of success on a measure of occupational functioning than were treatment factors; on the other hand, treatment factors were more predictive of success in achieving reduced levels of alcohol consumption. Finally, Polich and his colleagues (1980) found that those who never attended AA showed more improvement following treatment than did regular AA attenders when improvement was measured in terms of drinking without problems; the reverse pattern obtained, however, when improvement was measured in terms of abstinence.

The issue of validity is not the sole, or even the more important, reason to advocate use of multiple indicators. The question of treatment objectives must also play a major role in deciding how to measure treatment success. Many researchers maintain that the thrust of treatment should be to try to help the alcoholic with all of his or her major psychosocial problems, not just with his or her drinking (Baekeland 1977; Foster et al. 1972; Mandell 1979). According to this perspective, drinking is of no interest or significance unless it leads to negative physical or psychosocial consequences, and conversely, if treatment has no affect on the dysfunctional behaviors associated with drinking, then reduction of alcohol consumption is of no real value. Even if drinking behavior is changed, there may still remain psychosocial disabilities that preclude successful rehabilitation. Thus, multiple outcome measures appear necessary for an adequate assessment of treatment success.

Summary and Discussion

Of the many different measures used to indicate treatment outcome, indexes related to drinking—consumption, physical symptoms, and behavioral consequences—seem to more closely reflect the immediate effects of treatment than do measures of psychosocial functioning. However, conclusions regarding treatment success or failure vary according to the outcome criterion selected. This variation has led a number of investigators to advocate the use of multiple indexes of improvement, and to

stress that success is not dependent upon abstinence alone.

This "shot-gun" approach to measurement is not unlike the comprehensive treatment approach practiced by most programs. Both are advocated for the same reason: the combined approach may be the best currently available, given the present state of our knowledge. Nevertheless, our long-range goal should be to tailor specific outcome measures to fit specific types of clients.

How can the appropriate match between client and outcome index be determined? Perhaps the most meaningful guidance may come from the clients themselves. The treatment goals of alcoholic clients are often very different from the outcome measures applied by evaluators (Mandell 1979). Desired outcomes may include increased self-esteem, relief from depression, or release from distressing life situations that contribute to problem drinking. It is misleading to rely on temporary reduction in alcohol consumption as the sole indicator of success when factors that underlie the drinking problem are not also addressed. Similarly misleading are indicators that arbitrarily define occupational and marital stability as positive, since in some cases clients would benefit more from a dissolution of these involvements. It is therefore important to take into account the client's own treatment objectives in selecting appropriate indicators of treatment effectiveness.

Findings by Polich and associates (1980) highlight the value of also using clients' beliefs about alcoholism as a basis for selecting outcome measures. Nonproblem drinkers were shown to differ from problem drinkers and abstainers in their beliefs about alcoholism. Both abstainers and problem drinkers tended to hold traditional views of alcoholism: that alcoholism is an irreversible disease, that they themselves are alcoholics, and that they will be severely hurt by future drinking. Nonproblem drinkers, on the other hand, tended to reject these traditional beliefs. These findings suggest that total abstinence as a therapeutic goal (and attendant index of success) may be appropriate only for clients who accept the traditional views of alcoholism.

The use of multiple criteria in assessing alcoholism treatment outcomes represents a substantial improvement over exclusive reliance upon measures of alcohol consumption. However, evaluators should move toward tailoring outcome measures to fit the particular client assessed, using the client's unique goals, beliefs, and lifestyle as bases for indicator selection.

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NIAAA Study On Health Insurance In The States Completed

By April 1980, exactly half of the States had enacted legislation that either mandated health insurance benefits for alcoholism treatment services or required insurers to offer such benefits; eight more States had enacted similar legislation by the end of September 1981. Since this substantial portion of State legislatures had felt a need to ensure or encourage the provision of benefits for alcoholism services through the enactment of such legislation, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) undertook a study of the experiences of States with regard to legislation mandating or requiring the offering of health insurance coverage for alcoholism treatment services, and legislative alternatives in this area that States might want to consider in the future. The study, conducted by Science Management Corporation of Washington, D.C., sought:

- To describe the process of development of legislation for health insurance coverage for alcoholism at the State level
- To obtain assessments of the effectiveness of such legislation from key groups and individuals within each of eight case-study States
- To develop alternative legislative approaches to health insurance coverage of alcoholism treatment

Methodology

Subsequent to a review of relevant prior studies and research, the first major phase of this study consisted of telephone contacts with representatives in each State. At least two and often three or four individuals were interviewed by telephone in each State. The usual contacts included one representative each from the State Alcoholism Authority's office and the State Insurance Commissioner's office. Some of the other usual information sources included legislative staff, legislators, Blue Cross/Blue Shield or other health plan or insurance carrier representatives, and persons from alcoholism constituency groups. In States where legislation was defeated, at least three persons were interviewed, including at least one supporter and one opponent of the legislation, and at least one Blue Cross/Blue Shield representative.

Each respondent to the telephone survey was interviewed about all legislative proposals and actions related to health insurance coverage for alcoholism services in that State, including legislation that had been passed, defeated, or was pending. Copies of all bills and statutes were collected and analyzed.

Concurrently, contact was developed with relevant resources including health insurers, the National Conference of State Legislatures, NIAAA, independent investigators, and others. This information was used in the development of site selection criteria for the case study visits to eight States. The selection criteria included not only the requirement that five of the States have mandatory legislation and three have required option (offer) legislation but also consideration of date of legislative enactment and implementation; utilization and reimbursement rates of hospital and nonhospital alcoholism treatment providers in the State; status of State licensure and accreditation requirements; geographical dispersion of the States; and State size and the socioeconomic characteristics of the population. The eight States selected by NIAAA for the onsite case study visits were Connecticut, Maryland, Massachusetts, Michigan, Minnesota, Oregon, Rhode Island, and Wisconsin.

Where possible, personal interviews were conducted in these States with representatives of State Alcoholism Authorities, State Insurance Commissioners, Blue Cross/Blue Shield, commercial health insurers, alcoholism treatment providers, alcoholism consumer and constituency groups, employers, unions, and legislators or their staff. The number of interviews in different States ranged from a minimum of 13 to a maximum of 19.

In addition, information from other primary and secondary data sources was analyzed. An analysis of information and tables from the 1979 and the 1980 National Drug and Alcoholism Treatment Utilization Survey (NDATUS) was developed. This allowed comparisons across

States with different types of legislation on critical variables, such as the amount of private health insurance dollars reimbursed per capita for alcoholism treatment services overall; different types of alcoholism facilities (e.g., hospitals, free-standing units, community mental health centers); and different types of alcoholism services (detoxification, rehabilitation, outpatient).

A special National Advisory Panel was convened, consisting of 11 individuals chosen to represent a broad spectrum of interest groups ranging from commercial insurance carriers and Blue Cross/Blue Shield Associations to alcoholism service providers at State and local levels, and from attorneys with extensive experience in drafting legislative proposals to lay persons interested in improving alcoholism and other health care services. This group provided input and reaction to draft legislative alternatives.

Final Report

A final report, Status of State Legislation and Research on Health Insurance Coverage for Alcoholism Treatment, is available, as part of a health insurance resource kit, from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

State Legislation On Health Insurance Coverage For Alcoholism Services: An Assessment

Editor's Note: The following article summarizes the findings and conclusions from a study of State legislation and research on health insurance coverage for alcoholism treatment, conducted by Science Management Corp. under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The article on page 48 discusses the scope and objectives of the study.

State statutes that mandate coverage for alcoholism treatment have increased revenues for alcoholism treatment services. The impact of State statutes that require the offering of health insurance coverage for alcoholism is less clear. Nonetheless, alcoholism treatment services in many States could be receiving more substantial revenue than is now the case. Restrictive statutes, regulations, and policies continue to limit reimbursement even where mandatory legislation exists. For example, many States reduce public grant and contract funding if third-party reimbursement is received by a program. Other States place dollar limitations on benefits. And treatment providers themselves limit reimbursement by virtue of inadequate billing and other procedures.

The major beneficiaries of State statutes that mandate health insurance coverage of alcoholism services have thus far been hospitals, private for-profit programs and prestigious not-for-profit programs. In order to maximize the level of health insurance reimbursements collected for treatment services, many, if not most, alcoholism programs need technical assistance in developing more adequate documentation of services, unit costing, and billing procedures.

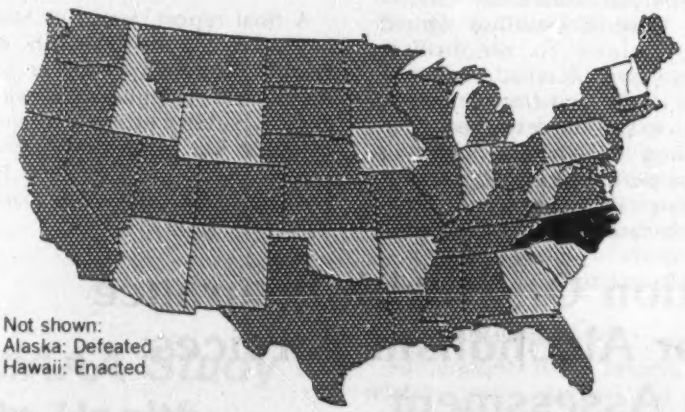
Beyond its contributions to service delivery, there exists a general consensus among representatives from the alcoholism field that health insurance coverage for alcoholism services helps to improve the accessibility of treatment services to clients and may also help to reduce the stigma associated with alcoholism. The effects of health insurance legislation in the States appear to be far reaching.

Status of Legislation

With the greater awareness that alcoholism is an illness, there has been a growing trend toward including alcoholism treatment as a health insurance benefit through State legislation. Although some insurance carriers have voluntarily incorporated alcoholism treatment benefits into their benefit packages, legislatures in a number of States have felt the need to expand health insurance coverage for alcoholism and to set forth minimum requirements for such coverage.

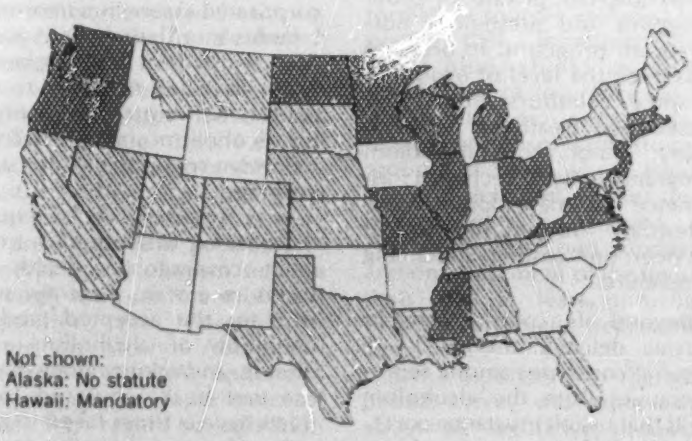
Laws that mandate or require the offering of alcoholism treatment coverage by health insurers in a State generally provide for the accepted medical definition of alcoholism as a disease, and acknowledge that in the past health insurance contracts have at times failed to provide adequate benefits for its treatment, and that the best interests of the State's citizens require that health insurance coverage be provided for the treatment of alcoholism. These laws are intended to facilitate early intervention into the

Figure 1.
Health insurance legislation enacted for alccholism treatment



NIAAA Study as of September 30, 1981

Figure 2.
Type of health insurance legislation enacted for alcoholism treatment



NIAAA Study as of September 30, 1981

illness and to result in cost and human savings for the individual citizen, the insurer, and the State.

As of September 30, 1981, 33 States had enacted laws on health insurance benefits for alcoholism treatment (figure 1). Similar legislation has been introduced and defeated in the legislatures of 16 other States. Only one State had not introduced bills in its legislature by September 30, 1981. Seventeen of the States that have enacted legislation require certain health insurance policies to pay for the treatment of alcoholism; another 16 require health insurance carriers to make such coverage available on an optional basis to employers, organizations, and other groups (figure 2).

All 33 State statutes cover group insurance contracts, while 13 of these statutes also cover individual insurance policies. Most statutes are specific about the types of treatment settings that should be reimbursed for alcoholism treatment services. Hospitals are specifically mentioned in 32 of the statutes as appropriate settings, are included by implication in the 1 statute in which no setting is specified, and are the only treatment settings covered by mandatory laws in 2 States. Freestanding alcoholism rehabilitation facilities are either specified or implied as appropriate settings in 29 State laws. Outpatient facilities are specifically mentioned in several State laws, but they are generally implied through language such as "facility providing services especially for treatment of alcoholism."

In an attempt to help assure quality of care, nine State statutes have specified provisions for licensure or accreditation usually including licensure, certification, or accreditation by the State or by the Joint Commission on Accreditation of Hos-

pitals (JCAH). Of the 33 States with legislation, 20 do not specify which health professionals are approved to provide services; of those States that do include a requirement, most specify physicians and a few include licensed psychologists; some States refer to service performed by or under the supervision of a physician or under a "Treatment Plan" approved by a physician.

Nine of the thirty-three States with statutes do not specify any benefit limitation, but the remaining 24 States include some form of benefit limits. Day or visit limits are included by nine States and generally range from 28 to 70 inpatient days per year and about 130 outpatient hours or 30 outpatient visits per year. Reimbursement limits are included by five States, and the minimums range from $500 per year to $4,500 per 24 months. A combination of unit and reimbursement limits generally involves setting inpatient days with a range of 30 to 45 days per year and outpatient costs at minimums from $500 to $1,000 per year. Eight States have included coinsurance and deductibles clauses, and they generally specify that coinsurance and deductibles for alcoholism services must be the same as for other illnesses.

Currently Federal law specifies that federally qualified health maintenance organizations (HMOs) must provide alcoholism treatment services for their enrollees. The insurance statutes in 10 States explicitly mention and include HMOs, and 8 other States have interpreted their insurance codes as including HMOs under the provisions of their health insurance for alcoholism statute (figure 3).

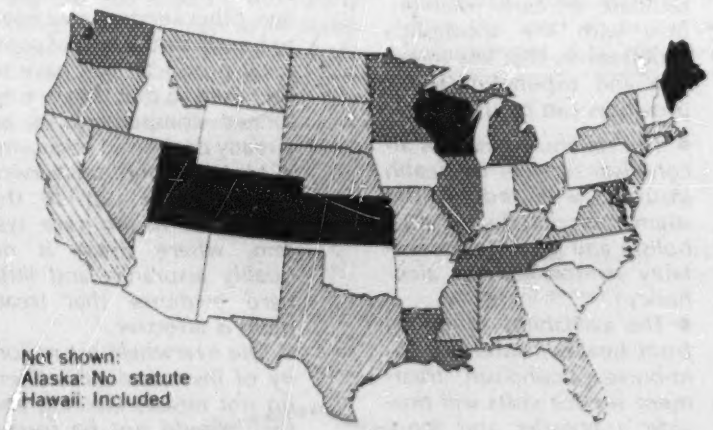
A number of States have included other relevant provisions in their alcoholism insurance legislation. For example, 9 States have included coverage for drug abuse, 2 States have included coverage for mental health services, 4 States have included coverage for both drug abuse and mental health services in addition to alcoholism services, and 11 States provide for physician involvement in alcoholism services ranging from referral to treatment to the actual provision of treatment.

Mandatory Coverage: Pros and Cons

The primary arguments offered in support of legislation to provide mandatory insurance coverage for alcoholism treatment services were as follows:

- *Alcoholism is a disease for which treatment should be reimbursed by health insurance providers on the same basis as any other disease or illness.* Related arguments include the belief that alcoholics should not be discriminated against and denied benefits by insurers because of their disease and that no special limits should be imposed by insurers.
- *The provision of benefits to treat alcoholism constitutes a responsible, effective, and humane social policy in response to the enormous public health problem and suffering caused by alcoholism.* Related arguments include the conviction that the provision of insurance benefits for alcoholism treatment services will save lives, improve people's health and well being, salvage families, and improve the job performance of persons who use the services.
- *The provision of alcoholism benefits will in the long term cut costs and save monies for both in-*

Figure 3.
Status of HMO coverage under health insurance legislation for alcoholism treatment



NIAAA Study as of September 30, 1981

surers and subscribers. This reasoning is based on the assumption that the alcoholic already receives many health care services and that he or she is a heavy user of those services. Once an individual is accurately diagnosed as an alcoholic and treated for that illness, then the person's health will not continue to deteriorate, the more intensive and expensive medical services will no longer be necessary, services can be provided within less expensive freestanding alcoholism treatment facilities, future accidents may be prevented, and the alcoholic's ongoing use of health care benefits will be reduced. Also, accurate and early diagnosis and treatment is the most cost-efficient and effective way to deal with the problem of alcoholism. For those States attempting to pass coverage for outpatient services, this argument is extended to indicate that outpatient services will facilitate an early intervention with the alcoholic's problems so that less intensive and expensive service providers can be used.

- *The reimbursement of alcoholism services by health insurers will reduce the stigma associated with alcoholism and improve accessibility to services for alcoholics.*
- *The availability of money from health insurers to reimburse alcoholism treatment service costs will provide a broader and more stable financial base for alcoholism programs.* Many alcoholism programs have been supported entirely or primarily by government monies.

The primary arguments offered in opposition to legislation that mandates insurance coverage for alcoholism treatment services are as follows:

- *Individuals, companies, unions, and other groups should be free to purchase the specific types of health insurance coverage that they wish—individual choice and the free competitive marketplace should be safeguarded and not be infringed upon by legislative mandates.*
- *Mandatory benefits may increase costs and premiums to such an extent that individual and group subscribers may not be able to afford comprehensive insurance coverage.* Little hard data exists on the utilization rates and costs of alcoholism services by insurance subscribers. Therefore, in order to protect against major losses, insurance premiums may have to be raised to such an extent that individuals, companies, unions, or other groups may no longer be able to afford comprehensive health insurance coverage, other services may need to be cut, or the cost of company products may have to be raised so that they are no longer competitive in an already depressed economy.
- *Many alcoholism service providers are outside the traditional health care system, where there is no quality assurance and little hard evidence that treatment is effective.*
- *The overwhelming majority of insurance subscribers do not misuse alcohol, and they should not be forced to pay for the self-inflicted problems of those persons who choose to drink and abuse alcohol.* The proper response to alcohol abuse is for the individual involved to moderate or stop his or her own drinking. The insurance premiums collected from the majority of insurance subscribers should not have to be used to pay for the self-inflicted problems of a few.
- *The mandating of alcoholism services will hasten the trend to self-insurance by companies, resulting in the loss of quality and comprehensive health insurance for many subscribers.* Since employers wish to avoid costly and complicated service mandates, there is an increasingly strong trend toward self-insurance, a mechanism through which all mandates can be circumvented. Ultimately the customer and insurance subscriber will lose because such self-insured plans are not subject to the many safeguards within State insurance laws relating to areas such as financial stability and solvency standards.

Impact of Legislated Coverage

Does State-legislated health insurance coverage make a difference in availability of services or funding of treatment programs?

Reimbursement Levels and Patterns. Information collected by the National Drug and Alcoholism Treatment Utilization Survey (NDATUS) indicates that 287 of 608 hospitals received private health insurance as a source of reimbursement for alcoholism treatment services and that only 306 of 2,290 freestanding alcoholism treatment facilities received reimbursement from health insurance (figure 4). The NDATUS survey was conducted jointly by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) in 1979 and 1980 and collected data on treatment utilization, staffing, and

financial resources of alcoholism or drug abuse or combined treatment programs. It is estimated that 95 percent of all organized alcoholism treatment programs, both hospital based and nonhospital based, throughout the Nation and territories were reported on in the September 30, 1980, NDATUS study.

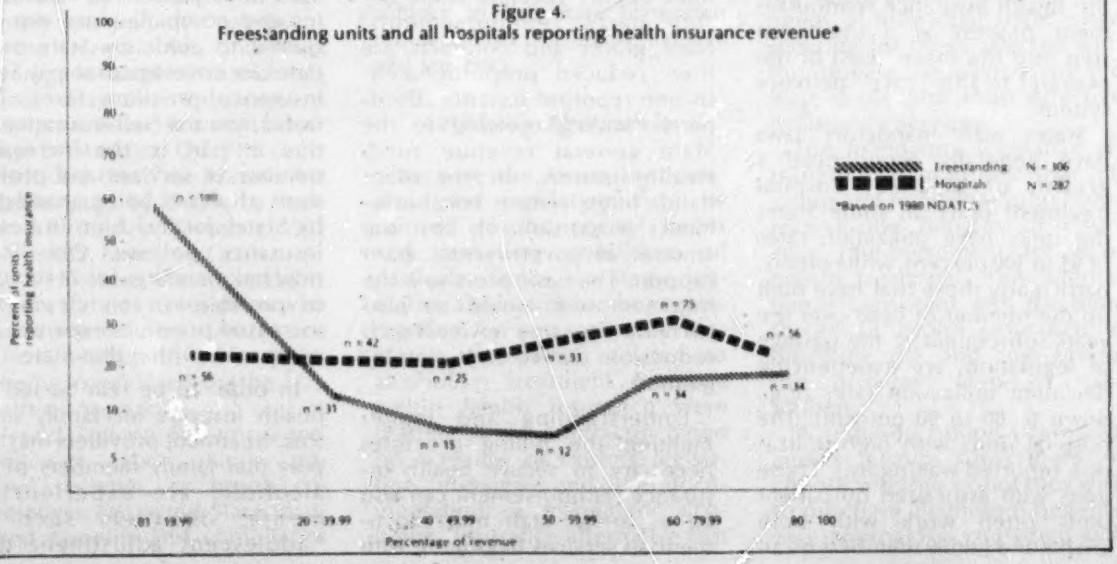
Aside from levels of reimbursement, it is interesting to examine the revenue patterns among the various provider groups. Over the past decade, the methods for financing alcoholism treatment for nonhospital or freestanding units has primarily revolved around public funds from Federal, State or local tax bases.

The freestanding units receiving private health insurance reimbursement receive less Federal, State, and local government funds than other freestanding alcoholism treatment units; of the 306 freestanding facilities that receive private health insurance, 232 receive no direct or indirect funding from NIAAA. In part, this trend away from public funding is consistent with other project findings that Federal and State grant funding reduces health insurance reimbursement, and that some State statutes or policies require treatment programs receiving State funds and health insurance reimbursement to either reimburse the State with the insurance receipts or have their State funds reduced accordingly.

The 1980 NDATUS data were analyzed to determine what differences, if any, mandated or optional health insurance statutes made in the level of insurance reimbursement. The findings show significant differences in the level of insurance reimbursement received by alcoholism treatment facilities in States with mandatory laws from levels in other States, while there is only a slight difference between States with required option laws and those with no statutes. The median health insurance reimbursement per capita in States with mandatory law, is $1.20. This level of insurance reimbursement for alcoholism services is more than twice as high as in States with required option statutes where the median is $0.57, and nearly three times as high as in States with no relevant statutes where the median is $0.41.

There are a variety of factors, beyond the type of State statute, that influence the level of health insurance reimbursement received by programs for alcoholism services: the level of insurance coverage for alcoholism services already available in the State through voluntary inclusion of coverage by insurers or voluntary purchase of coverage by employers; the aggressiveness of alcoholism programs in their pursuit of third party funding; the level of support given by State Alcoholism Authorities for such activities by encouraging program accreditation by the Joint Commission on Accreditation of Hospitals; and the type of delivery system for alcoholism services in the State (a hospital-based delivery system for inpatient alcoholism services tends to receive much higher levels of insurance reimbursement than a system that concentrates on outpatient services provided by free-standing alcoholism treatment programs). In addition, the precise provisions of the individual State statutes influence the level of insurance reimbursement, e.g., the types of

Figure 4.
Freestanding units and all hospitals reporting health insurance revenue*



treatment settings that are covered; and limits on the number of days, visits, or dollars that are covered; the types of individual providers who are covered; and the date of implementation of the law. Nevertheless, both common sense and the magnitude of the difference in reimbursement clearly indicate that the type of health insurance coverage legislation that is enacted within a State can have significant effects on the level of private health insurance reimbursement provided for alcoholism services within the State.

Availability of treatment services. Subjective data collected in interviews with various key groups in eight states that have enacted laws, shows that mandated coverage does contribute to encouraging people with alcohol problems to seek help at an earlier stage in the disease process. Respondents were unanimous in their opinion that all types of insurance laws have improved accessibility to treatment and helped reduce the stigma still associated with alcoholism. They viewed the inclusion of alcoholism services in the health insurance reimbursement process as a significant step into the mainstream of the overall health care delivery system.

States with mandatory laws have generally experienced a growth of inpatient hospital treatment units. In some States the units have utilization rates of 95 to 100 percent, while others, particularly those that have built up the number of beds over the years subsequent to the passage of legislation, are experiencing declining utilization rates (e.g., down to 80 to 90 percent). The hospital units with high utilization reported waiting lists. Those units with associated outpatient units often work with both clients and family members on an outpatient basis until clients can be admitted into the unit.

Problems with reimbursement. The consensus among many respondents was that private, profit-making, and prestigious nonprofit alcoholism treatment programs have been the major benefactors of health insurance legislation. State and federally funded nonprofit facilities have generally had marginal to no direct benefits from the laws, even though many people assumed that such laws would provide a stable financial resource to nonhospital treatment units. Reimbursements have not been obtained by many facilities because many of the clients served do not carry health insurance, or in some instances, the programs have not established billing procedures.

The publicly funded alcoholism treatment programs have unique problems with regard to receipt of health insurance reimbursements. These problems are the result of both State statutes and policies and health insurers' policies. On the one hand, many States require, via statute or policy, that treatment units receiving State funding must report receipts from any third-party reimbursements. State grants and contracts are then reduced proportionately. In one reported instance, third-party funding reverted to the State general revenue fund. Health insurers, on the other hand, often reduce reimbursements proportionately by the amount of governmental grant support. The basic premise is the treatment unit would be paid twice for the same service if such reductions were not implemented.

Understanding and implementing the billing processes necessary to secure health insurance reimbursement can also be a barrier; staff must document all services beginning with an individual's admission to treatment and continuing to discharge. In addition, it is essential to determine the specific type of health insurance coverage held by the client and any and all special requirements of the health insurer. According to some respondents, the development and ongoing implementation of billing procedures will require technical assistance from the SAA and the health insurers before reimbursements can be successfully obtained for the services rendered.

Insurers generally require treatment programs to develop an established fee schedule before they will negotiate a provider agreement or provide reimbursement. Insurers will reimburse no more than the maximum amount in the fee schedule subject to public grant provisions.

Many health insurers report a growing trend for companies to not use traditional health insurance carriers and instead to become self-insured. A report from one State indicates that the proportion of self-insured company employees has grown dramatically: from 5 percent in 1975 to 25 percent in 1980. Self-insured companies are not required to abide by State mandates for coverage or to pay State insurance premium taxes. The trend toward self-insurance is due in part to the increasing number of services and professions that are being mandated by States for inclusion in health insurance policies. One State now has mandates for 24 services or professions; this clearly has increased premium expenses for companies within that State.

In order to be reimbursed by health insurers for family services, treatment providers may report that family members of an alcoholic are experiencing mental disorders such as "adolescent adjustment dis-

order" or "stress." Most State statutes do not address family coverage related to alcoholism treatment.

Significant Issues

As health insurance legislation becomes more commonplace, several significant issues have emerged.

Litigation. State laws mandating health insurance coverage for alcoholism and drug abuse have been challenged in court in Hawaii and Minnesota because of statutory provisions of application to self-insured companies and extraterritoriality, respectively. In Hawaii, the U.S. Court of Appeals for the Ninth Circuit upheld a ruling in *Standard Oil Company of California* v. *Joshua C. Agsalud et al.* that the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001-138, preempts the Hawaii Prepaid Health Care Act. Shortly after the enactment of ERISA, Hawaii passed a comprehensive health care plan that required employers to provide their employees with a prepaid health care plan. Standard Oil, with a self-insured health plan for its employees, which was covered by ERISA, did not comply with all the provisions of the Hawaii Act, including coverage for alcoholism and drug abuse. Hawaii's enforcement attempts resulted in a court challenge by Standard Oil. The court concluded that "the Hawaii Act is preempted by ERISA," a decision affirmed in October 1981 by the U.S. Supreme Court.

In Minnesota, the applicability of State statutes to residents who are covered by insurance policies written in other States is being considered by the U.S. Court of Appeals.

Trend Toward Self-insurance. Employers, labor unions, fraternal societies, or health cooperatives can avoid State mandated benefits and compliance problems either by dropping their health insurance benefit programs and/or by changing to a self-insured plan. Such plans provide protection in the amount that is desired by the group. These plans are under the jurisdiction of the Federal Employee Retirement Income Security Act of 1974 (ERISA), which preempts State law.

In the past several years, there has been a major shift to Administrative Services Only (ASO) and Minimum Premium Plans (MPPs). Under these systems, employers and other organizations can establish self-insured plans. The insurance carrier, or plan, is paid a fee by the self-funding group or organization for the claims processing. Under MPPs, they insure against a certain level of large, unpredictable claims. These systems now account for approximately 25 percent of all group health insurance coverage, up from five percent prior to 1975. The self-insured plans are not subject to State insurance laws (such as alcoholism coverage mandates); not subject to State premium taxes; not subject to catastrophic coverage; not required to provide for conversion; and not subject to the State insurance requirements for fiscal stability and solvency.

Legislative Alternatives

Because the issues are complex, and legislation must be tailored to the special needs and prevailing conditions of particular States, no single legislative alternative can be recommended. Consequently, four legislative alternatives related to alcoholism treatment coverage within health insurance were drafted by the contractor based on a review of existing legislation, interviews, and other documentation: a mandatory alcoholism insurance alternative that requires most health insurers to provide coverage for the treatment of the disease of alcoholism; a required option alcoholism insurance alternative that requires health insurers to offer alcoholism treatment coverage to policyholders in writing and requires that the policyholder accept or decline the coverage in writing; a mandatory alcoholism and drug addiction insurance alternative to provide health insurance coverage for the treatment of alcoholism and drug addiction; and a required option alcoholism and drug addiction insurance alternative.

Of the 33 States with alcoholism health insurance statutes, 12 have a mandatory statute, 16 have a required option statute, and 5 have a statute that includes both mandatory and required option provisions. Also, 12 States have combined alcoholism and drug abuse treatment statutes. These legislative alternatives afford State jurisdictions, legislatures, State Alcoholism Authorities, State insurance departments, the insurance industry, and alcoholism providers flexibility in developing legislation to best suit the needs of individual States while securing for those affected with the disease of alcoholism the least costly and most effective health care services.

The mandatory legislative alternative guarantees that all group and individual subscribers receive the benefits of insurance reimbursement for alcoholism treatment. This alternative is consistent with the basic theory of health insurance to distribute risk and cost among the broadest class of subscribers.

A required option alternative allows group subscribers to choose whether or not they wish to purchase alcoholism benefits. This approach is consistent with

the position of the insurance industry of freedom of contract, the right of an insurer and subscriber to negotiate freely in the open marketplace for benefits and costs tailored to meet the specific needs of a subscriber. Historically, this viewpoint is deeply rooted in the American free enterprise system. Nevertheless, several States regulate approval of health insurance contract benefits to ensure that highly complex contracts include basic benefits for unforseeable illness that statistically impacts on a significant portion of the insured population.

An opposite view is that, because of the nature of the disease of alcoholism, the tendency of a potential subscriber to deny the disease, and the lack of public awareness, only a minute fraction of subscribers would choose an alcoholism benefit. In such cases, the lack of foreseeability of the possibility of alcoholism effectively precludes appropriate treatment for a significant proportion of the insured population who will statistically require treatment. In order to be effective, required option benefits require a high degree of consumer awareness and subscriber participation in the decision to select or reject any alcoholism benefits. Both this required option alternative and the required option alternative that offers coverage for alcoholism and drug dependency specify that the insurer must offer the benefits in writing and the policyholder must decline in writing. This is intended to ensure that the customer is aware of the choice to purchase benefits.

The mandatory alcoholism and drug abuse health insurance alternative guarantees that all group and individual subscribers receive the benefits of insurance coverage for the treatment of both alcoholism and addiction to or abuse of prescription and other drugs. The course of treatment reimbursable under this alternative would be set forth in the patient Treatment Plan and could include individual or group counseling for alcoholism or drug addiction, as prescribed by a physician or legally qualified health care practitioner. Eligible providers include hospitals, and if alcohol or drug treatment is prescribed in the Treatment Plan, any detoxification, residential or outpatient, or partial hospitalization program specifically licensed, approved, or accredited by the State to provide alcohol or drug addictiontreatment services.

The required option alcoholism and drug dependency insurance alternative allows group subscribers to choose whether or not they wish to purchase insurance coverage for the treatment of alcoholism and addiction to drugs.

Health Insurance Benefits For Alcoholism Treatment: The Industry's Accomplishments

A review of information from the Blue Cross and Blue Shield Associations indicate that several plans offered alcoholism services benefits to subscribers prior to passage of State legislation requiring or mandating the benefits. The Blue Cross and Blue Shield Plan of Maryland began offering its Alcoholism Series, which included residential rehabilitation and outpatient benefits, in 1974. The Maryland legislature adopted a required option law in 1976 and a mandated law in 1980. The Alabama and Michigan Plans also offered alcoholism treatment benefits prior to the States' enacting required option laws and mandatory laws, respectively.

Blue Cross and Blue Shield Plans currently offer benefits for alcoholism services in other States that have not enacted laws requiring or mandating the benefits, including Delaware; Iowa; New Hampshire and Vermont; Albany, Syracuse, Rochester, and Buffalo in New York; Philadelphia and Harrisburg in Pennsylvania; and Idaho.

Many of the Plans' offerings include benefits for both residential rehabilitation and outpatient programs. A number of Plans adopted these benefits based upon a model benefit structure developed by Blue Cross and Blue Shield Associa-

tions under a contract from NIAAA. Some individuals can also have treatment covered under their basic medical coverage without a specific rider for the disease of alcoholism.

Private carriers began offering benefits for alcoholism treatment in the early 1970s. Kemper Insurance Company began covering alcoholism in the same manner as other illnesses in 1973; Prudential Insurance Company dropped its standard exclusion of alcoholism treatment in 1972.

Federally qualified Health Maintenance Organizations (HMOs) have been required since the mid 1970s to include treatment of alcoholism and drug addiction for its members. The services include short-term outpatient services, inpatient or outpatient detoxification, and medically necessary emergency services.

Major medical insurance provides a broad coverage for large medical expenses. It covers a wide range of medical charges with few limits and usually a high maximum benefit. Of the more than 181 million citizens in 1978 who were covered by one or more private health insurance policies, 142 million had major medical coverage. This coverage usually requires a deductible and copayment by the insured. Payments under major medical may be made directly to the insured.

NAIC Task Force

In early 1980, an indepth study of the complicated issue of third-party reimbursement for chemical dependency was initiated by the National Association of Insurance Commissioners (NAIC). A task force was appointed, consisting of the insurance commissioners from Florida, Minnesota, Nevada, and Texas. In September 1980 a 32-member advisory committee was appointed to assist the task force. The members of the advisory committee were chosen to represent three different perspectives, including professionals working in alcoholism and drug addiction treatment, employers, and insurance industry representatives. It also included individuals of differing philosophical perspectives. Three subcommittees were established: a Subcommittee on Benefits, a Subcommittee on Statistical and Actuarial Data, and a Subcommittee on Legislation. Each of these subcommittees developed a report that was in turn reviewed, modified, and adopted by the NAIC Advisory Committee and the NAIC Task Force.

The Model Benefit Structure for Alcoholism and Other Drug Dependency proposed by NAIC is designed for group insurance contracts only. It covers treatment in both hospital-based and freestanding inpatient and outpatient care settings, includes a broad variety of covered services ranging from medical evaluation and individual and group counseling to outpatient family therapy, recommends a lifetime maximum of two benefit periods, and specifies that, "subject to physician certificate of medical necessity and appropriateness within 10 days of the start of treatment," 30 days of inpatient care and 30 outpatient visits should be covered. The report submitted by the Subcommittee on Statistical and Actuarial Data attested to the need for further research on the specific effects of alcoholism and drug addiction treatment coverage on insurance costs. Although the report indicates that "there seems to be some evidence of ultimate reduction in medical care utilization on the part of rehabilitated individuals," because of the lack of definitive research findings the Subcommittee felt that the tradition of experience rating would serve to contain costs, and that competitive forces among insurers would "virtually guarantee that any initial extra charge will be at a minimum required level." Finally, the Subcommittee on Legislation developed a succinct model act designed ". . .to encourage consumers to avail themselves of basic levels of benefits under group health insurance policies and contracts for the care and treatment of alcohol and other drug dependency, and to preserve the rights of the consumer to select such coverage according to his medical-economic needs." The model act requires that insurers offer alcohol and drug addiction treatment coverage to group (not individual) subscribers and that such subscribers can choose to accept or reject such coverage based on their assessment of their own needs. So far, the State of Texas has adopted the model legislation; other States are in the process of considering the NAIC model act.

For further information on the model benefits packages mentioned in this article, contact Blue Cross/Blue Shield, 679 N. St. Clair, Chicago, Illinois 60611, attn. David Strachen; and the National Association of Insurance Commissioners Task Force, c/o Rob LaRue, State Board of Insurance, 1110 San Jacinto, Austin, Texas 78786. Health insurance resource materials are available from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, Maryland 20852; request EN8050 for a listing.

For information in your own state, contact the State Insurance Commissioner, the insurance committee of the State legislature, or the State Alcoholism Authority.

FACTS FOR PLANNING NO. 6

Parental Dimensions In Teenage Drinking

Cherry Lowman, Ph.D.

Do parents' drinking practices—as perceived by their youngsters—influence teenagers' drinking? And how about parental attitudes toward teenage drinking? Are teenagers' drinking practices affected by their perceptions of parental attitudes? And finally, does teenagers' drinking lead to problems with their families? Self-report national survey data collected in 1978 suggest the answers to these questions is yes. The survey of drinking practices among 10th to 12th grade students was conducted by the Research Triangle Institute (RTI) with funding from the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse (see technical notes for details).

Parental drinking. More alcohol-using senior high school students were found in homes where alcohol was present. Parents' and teenagers' drinking behavior was found to be generally similar. RTI researchers noted, however, that there has been "wide variety in the strength of this association." They also noted that it is strongest between fathers and sons, between mothers and daughters, and for girls in general (Rachal et al. 1980).

According to the 1978 survey, an estimated 85 percent of the Nation's 11,180,409 senior high school students believed they had at least one parent who drank alcoholic beverages. An estimated 33 percent had fathers they believed were regular alcohol users, 12 percent had mothers believed to use alcohol regularly, and 9 percent believed both parents to be regular drinkers. Approximately half (49 percent) of the students had fathers who they reported used alcohol at least sometimes and 52 percent had mothers who they reported sometimes used alcohol; 33 percent of students believed both parents sometimes used alcohol.

Highlights of 1978 RTI Findings

- Eighty-five percent of senior high school students had at least one parent who they believed drank alcoholic beverages; an estimated 9 percent said both parents drank regularly.
- Students' drinking levels were associated with their perceptions of their parents' drinking behavior. An estimated 59 percent of all students with at least one parent who they believed drank regularly were themselves moderate to heavier drinkers, compared with 29 percent of students who believed their parents were abstainers.
- Levels of teenage alcohol use were related to teenagers' perceptions of parental attitudes toward teenage drinking. Of boys who said their parents disapproved of boys' drinking, only 17 percent were heavier drinkers, compared with 35 percent who believed their parents approved. Similar patterns were observed among girls.
- The more senior high school students drank, the more likely they were to report getting into trouble with their families because of their drinking. Over 2 million students—20 percent—were estimated to have gotten into trouble with their families over drinking during the previous year, based on self-report data.
- Students who often drank when they participated in peer activities unsupervised by adults were more likely to report getting into trouble with their families because of their drinking than were students who reported they often drank in supervised settings.
- The highest levels of reported drinking-related family problems occurred among senior high school students who said they often drank when they were alone or when they drove around in cars at night.
- An estimated 74 percent of senior high school students who reported driving while intoxicated six or more times during the previous year reported they got into trouble with their families because of their drinking, in contrast with only 18 percent who said they had not driven while intoxicated.

Correction. *In* Facts for Planning No. 5 (AH&RW *6(3): 71*), *percentages were omitted in Figure 1. Age at which alcohol and marijuana were first used, as reported by senior high school students 1978. The percentages on the vertical axis of this graph should have been 0,2,4,6,8,10, 12,14,16.*

(See the technical notes for the questions upon which these responses are based.)

On the basis of answers to a series of questions about the quantity and frequency of respondents' own alcohol use, researchers assigned students to one of six drinking levels. (See the technical notes for definitions of the six levels.) Table 1 shows the relationship between perceived parental drinking practices and students' drinking levels. Of students who reported that one or both parents drank regularly, an estimated 19 percent were themselves heavier drinkers, as compared with 15 percent of students who reported their parents were alcohol abstainers. Of students who reported their parents were abstainers, over 50 percent were themselves abstainers; only 17 percent of students who reported their parents sometimes drank were themselves abstainers. And among those whose parents were believed to be regular drinkers, only 12 percent were abstainers.

It should be noted that it is primarily the high level of abstinence that distinguishes children of abstainers from other teenagers. When children of abstainers do drink, their patterns of use are more similar to those of other teenage drinkers. For example, among children of abstainers who do drink, 16 percent are heavier drinkers, 6 percent less than the 22 percent of student drinkers whose parents are regular users of alcohol.

Parental Attitudes Toward Teenage Drinking. Among family correlates, the strongest relationship was between students' drinking levels on the one hand and parents' perceived attitudes toward teenage drinking on the other.

An estimated 70 percent of senior high school students in 1978 believed their parents disapproved of boys' drinking, while 73 percent believed their parents disapproved of girls' drinking. However, parental disapproval of teenage drinking was ameliorated in part by parental alcohol use. Parents who were reported to be regular drinkers were less often perceived as disapproving of their sons' and daughters' drinking. For example, only 58 percent of boys who reported their fathers drank regularly believed their parents disapproved of 'boys' drinking. In contrast, 84 percent of boys who said their fathers were abstainers reported parental disapproval of boys' drinking. Similarly, 54 percent of girls whose mothers were perceived to be regular drinkers said their parents disapproved of girls' drinking; 85 percent of girls who classified their mothers as abstainers reported parental disapproval of girls' drinking.

In general, the relationship between perceived parental attitudes and actual student drinking was clear and direct. Of boys who reported that their parents disapproved of boys' drinking, 17 percent were heavier drinkers and 29 percent were abstainers. Contrast this with boys whose parents were perceived to approve of boys' drinking; 35 percent of these boys were heavier drinkers and 9 percent were abstainers. The pattern was the same for girls. Of girls who believed their parents approved of girls' drinking, 18 percent were heavier drinkers and 14 percent were abstainers. Only 7 percent of girls who reported parental disapproval of girls' drinking were heavier drinkers, while 31 percent were alcohol abstainers.

Table 2 reveals a strong association between parental attitudes toward student drinking and student drinking levels. The extent of perceived approval of drinking was progressively greater as drinking level increased among both boys and girls. The same pattern was seen among those who believed their parents didn't care whether or not they drank, a parental attitude apparently serving as passive approval. Conversely, the percentage of boys and girls who perceived their parents to disapprove of drinking decreased progressively as each drinking level increased. Only among boys and girls who could not or did not identify an explicit

Table 1. Perception of parents' alcohol use by drinking levels, 10th-12th grade[1]

Students' drinking level	Perception of parents' alcohol use		
	One or both parents drink regularly	One or both parents drink sometimes	Neither parent drinks
Abstainer	12.4%	17.1%	51.1%
Infrequent	9.9	14.3	5.7
Light	19.2	19.5	13.8
Moderate	18.4	17.6	10.0
Moderate/ heavy	21.5	16.6	11.4
Heavier	18.6	14.9	8.0
Total	100.0%	100.0%	100.0%

[1]Excerpted from Table V.1 in the RTI final report to NIAAA (Rachal et al. 1980).

Table 2. Percentage of senior high school students in each drinking level distributed by parental attitudes toward drinking by sex, 1978

Parents' attitudes	Students' drinking levels						
	Abstainers	Infrequent	Light	Moderate	Moderate/ heavier	Heavier	Total
Parental attitudes toward boys' drinking				*Boys*			
Approve	2.6%	4.0%	4.7%	7.6%	8.8%	11.4%	6.8%
Don't care	5.9	12.9	8.0	13.0	17.9	22.4	13.5
Disapprove	84.3	68.2	73.9	71.0	61.2	58.0	69.7
Don't know	7.2	15.0	13.4	8.4	12.1	8.3	10.0
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Parental attitudes toward girls' drinking				*Girls*			
Approve	2.4%	2.3%	3.7%	7.2%	7.2%	9.8%	4.9%
Don't care	5.3	8.3	8.0	15.7	15.8	21.9	11.1
Disapprove	81.7	78.7	74.7	66.4	67.8	56.5	72.8
Don't know	10.5	10.7	13.6	10.7	9.2	11.9	11.1
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Interpret the percentages as follows: In 1978, an estimated 84 percent of boys who were alcohol abstainers had parents they perceived to disapprove of boys' drinking; in comparison, 58 percent of boys who were heavier drinkers had parents they believed disapproved of boys' drinking.

parental attitude (the "don't know" category in table 2) was there no clear relationship between parental attitudes and student drinking levels.

Although the prevalence of alcohol use was considerably higher among senior high school boys than among girls at all drinking levels (Lowman 1981), patterns of alcohol use related to perceived parental attitudes is remarkably similar for both sexes.

Problems with family related to student alcohol use. The 1978 RTI survey data reveal that the more frequently and heavily students drank, the more likely they were to report problems with their families related to their drinking. This suggests that a large number of parents attempt to monitor and intervene in their teenage sons' and daughters' drinking practices.

Over 2.2 million senior high school students—20 percent—were estimated to have gotten into trouble with their families because of their drinking at least once during the year prior to the survey. (See the technical notes for the question underlying this statistic.) Eleven percent reported they got into trouble with their families only once during this interval; 8 percent experienced such problems two to five times; and 1 percent had family-related problems six times or more.

The patterns of reported alcohol-related problems with family mirror the demography of adolescent drinking in the Nation. The number of students who said they had problems with their families was greater among boys (23 percent) than among girls (17 percent), in small towns (23 percent) and suburbs (20 percent) than in big cities (14 percent), in the Northeast (22 percent) and North Central (24 percent) regions than in the South (17 percent), and West (17 percent), and among whites (22 percent) and American Indians (25 percent) than among blacks (8 percent) and Asians/Pacific Islanders (14 percent). *Facts for Planning No. 1* discusses the demography of adolescent drinking (Lowman 1981).

Drinking contexts are also related to frequency of troubles with family because of drinking. *Facts for Planning No. 3* (Lowman 1981/82) discusses RTI findings on teenage alcohol use in unsupervised settings and explores questions underlying drinking context variables. In general, students who often reported they drank in unsupervised settings also were more likely to report alcohol-related family problems than were students who said they often drank in supervised settings.

Thirty-four percent of students who often drank at unsupervised teenage parties reported problems with their families related to drinking at least once during

the year prior to the survey. Thirty-eight percent of students who often drank during or after a school activity, 40 percent who often drank alone, and 41 percent who often drank alcoholic beverages while driving around or sitting in a car at night reported troubles with their families. Only 22 percent of students who often drank at home at dinner and only 15 percent of students who often drank at home on special occasions reported alcohol-related problems with their families.

An exception to this pattern linking unsupervised drinking with greater incidence of drinking-related family problems is among students who often drank at teenage parties with adults present. Of this group, 33 percent said they had problems with their families at least once, a figure comparable to those students who often drank in unsupervised settings. It is not clear if senior high school students drink more heavily at parties with peers present than in other social contexts where adults are present, or whether they are simply more likely to engage in unacceptable behavior in this context than in adult-supervised situations where peers are not present. It may be that,because of the party setting, driving is involved, causing parents to raise concerns about drinking and driving even though there may be adult supervision during the party.

The highest level of drinking-related familial problems occurred among students who said they often drank when they were alone or when they drove around or sat in cars at night. An estimated 16 percent of students who often drank alone reported they got into trouble with their families because of drinking two to five times during the previous year; 8 percent, six times or more. Correspondingly, 20 percent of students who often drank in cars at night reported problems with family related to drinking two to five times; 5 percent, six times or more.

The most striking association exists between the number of times students reported they drove a car while intoxicated during the year prior to the survey and the number of times they said they experienced family problems related to their drinking during the same period. As shown in figure 1, only 18 percent of students who had not driven while intoxicated during the previous year reported drinking-related problems with their families; in comparison, 38 percent of students who had driven once while intoxicated, 58 percent of those who had driven two to five times while intoxicated, and 74 percent of those who had driven six or more times while intoxicated reported at least one drinking-related family problem. Forty-eight percent of the last group experienced problems with their family six times or more during the previous year, compared with only 4 percent of those who had not driven while intoxicated.

The high correspondence between the reported frequency of students' driving while intoxicated and the reported frequency of troubles with family because of drinking probably reflects the fact that most parents are highly concerned about teenage drinking and driving because of the potentially serious consequences. It is also possible that young people who are driving while intoxicated are also engaging in other noticeable alcohol-related negative behaviors.

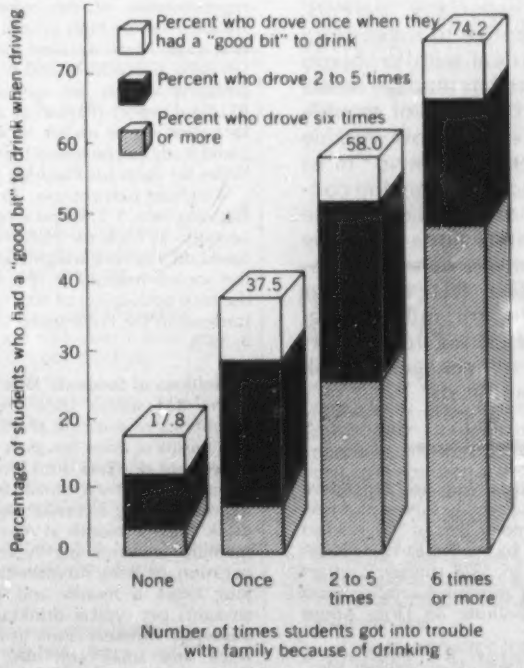


Figure 1. Percentage of senior high school students who had a "good bit" to drink distributed by number of times they got into trouble with family because of their drinking[1]

[1]Both measures refer to the time interval, "during the past year."

Implications

The 1978 RTI survey data indicate that teenagers' perceptions of parental drinking behavior and attitudes toward teenage drinking do influence teenage drinking, at least among adolescents who live at home. Although teenage drinking has been shown to be highly related to the number of friends who drink and the degree of consensus among friends about drinking (Rachal et al. 1980), students' perceptions of parental drinking behavior and attitudes remain important. This suggests that informed parents can be effective in reducing or preventing teenage alcohol abuse.

The fact that 20 percent of senior high school students got into trouble with their families at least once because of their drinking indicates that many family members, especially parents, may be receptive to suggestions on how to deal with problems and risks posed by teenage drinking. The occurrence of trouble with families was most notable among teenagers who most needed protection from the consequences of drinking—those who often drank alone and those who often drove cars while intoxicated. The RTI data thus suggest a need for and potential benefit to be gained from targeting parents of teenagers at risk in prevention efforts.

Technical Notes

RTI Survey Methodology and Procedure

A national probability survey of drinking practices among 10th to 12th graders was conducted by the Research Triangle Institute (RTI) in 1978, under contract to NIAAA with additional funding from the National Institute on Drug Abuse (NIDA).

Sampling strategy. RTI employed a three-stage stratified sampling strategy. The first stage involved selecting a probability sample of all counties in the 48 contiguous States and the District of Columbia, stratified by geographic region and community size. A second-stage probability sample was taken of all high schools in each county selected. At least one high school was chosen from each county and more than one from large counties. Finally, a probability sample of homerooms, one for each grade in school, was taken from the sample of high schools selected in the second stage. Questionnaires were self-administered by students grouped in homerooms or classes. Instructed and supervised by RTI-trained staff, students were assured that their responses would be anonymous and confidential.

Representativeness. In the 1978 study, some of the original, randomly selected sampling units were replaced, using probability measures. The "overall participation rate" in the final adjusted sample was 85 percent (the proportion of schools participating multiplied by the proportion of students participating).

The RTI sample was not representative of all the Nation's adolescents. Neither high school dropouts nor absentees were sampled. Both of these subgroups may manifest different drinking patterns from those that characterize the high school students. Further, inner city students and members of the ethnic groups other than "white" or "black" were probably undersampled. Nonetheless, the sample was representative of the majority of the Nation's senior high school students at that time. More detailed discussions on sampling procedures and evaluations of sampling validity are contained in the RTI final report (Rachal et al. 1980). Information on an earlier 1974 survey and panel study can be found in the Technical Notes for *Facts for Planning Nos. 1-5.*

Weighted percentages. As in *Facts for Planning* Nos. 1, 2, 3, and 5, reported percentages in *Facts for Planning No. 6* are based on a sample weighted to represent the sociodemographic characteristics of the total population of 10th to 12th grade students in the continental United States in 1978.

Definitions of Students' Drinking Levels

The RTI survey used the following definitions of drinking levels: **abstainers** don't drink or drink less than once a year; **infrequent drinkers** drink once a month at most and drink small amounts per typical drinking occasion; **light drinkers** drink once a month at most and drink medium amounts per typical drinking occasion, or drink no more than three to four times a month and drink small amounts per typical drinking occasion; **moderate drinkers** drink at least once a week and small amounts per typical drinking occasion, or drink three to four times a month and medium amounts per typical drinking occasion, or drink no more than once a month and large amounts per typical drinking occasion; **moderate/heavier** drinkers drink at least once a week and medium amounts per typical drinking occasion, or drink three to four times a month and large amounts per typical drinking occasion; and **heavier drinkers** drink at least once a week and large amounts per typical drinking occasion. *Facts for Planning* No. 2. provides more detailed definitions of these six drinking levels, and discusses the questions underlying them and the procedures used to construct the drinking level classification.

Variables Measuring Parental Attitudes and Drinking Practices

Students' perceptions of parental drinking practices were elicited by the following two questions:

> Q. Do you think that your father (or person who served as your father in raising you) ever takes a drink of beer, wine, or liquor?
>
> Q. Do you think that your mother (or person who served as your mother in raising you) ever takes a drink of beer, wine, or liquor?

The choice of responses included "Yes, fairly regularly," "Yes, sometimes," "No," "I don't know," and "Does not apply." Statistics reported here are based on distributions that exclude students who did not respond "yes" or "no"—8 percent of respondents to the question about father's drinking and 5 percent of the respondents to the question about mother's drinking.

Students' perceptions of parental approval of teenage drinking were measured by the following two questions:

> Q. How do you think your parents (or your family) feel about boys your age drinking?
>
> Q. How do you think your parents (or your family) feel about girls your age drinking?

Choice of responses included "Strongly approve," "Approve," "Don't care one way or the other," "Disapprove," "Strongly disapprove," and "I don't know." The distributions in table 2 are based on aggregated responses to these two questions. "Strongly approve" and "Approve" are reported as a single percentage, "Approved." The responses "Disapprove" and "Strongly disapprove" are also reported as one percentage, "Disapprove."

Questions Underlying Problems With Family and Driving While Intoxicated

An earlier 1974 survey asked a series of five questions about negative consequences of drinking experienced by respondents. Responses to these five questions were used to develop a definition of "problem drinkers" or "alcohol misusers." Statistics on the negative consequences of drinking and on alcohol

misuse in 1978 are reported in *Facts for Planning No. 4.*

In 1978, a sixth question was added to the negative consequences series: "During the past year, how many times have you gotten into trouble with your family because of your drinking?" Findings on the extent of problems with family related to drinking are presented for the first time in *Facts for Planning No. 6.*

Figure 2 is based on two questions in the negative consequences series, one about trouble with family and the other about the number of times "you've driven when you've had a good bit to drink."

Distributions for both measures are based on an aggregation of "2-3 times" and "4-5 times" into a single category "2-5 times." Likewise, the "6-9 times" and "10 or more times" responses have been combined into a single category, "6 times or more."

The negative consequences series of questions is presented below as it appears on the 1978 questionnaire.

During the past year, how many times have each of the following happened to you? Mark X on one black line in each row.

None	Once	2-3 times	4-5 times	6-9 times	10 or more times	
___	___	___	___	___	___	You've gotten into trouble with your teachers or principal because of your drinking.
___	___	___	___	___	___	You've gotten into difficulties of any kind with your friends because of your drinking.
___	___	___	___	___	___	You've driven when you've had a good bit to drink.
___	___	___	___	___	___	You've been criticized by someone you were dating because of your drinking.
___	___	___	___	___	___	You've gotten into trouble with the police because of your drinking.
___	___	___	___	___	___	You've gotten into trouble with your family because of your drinking.

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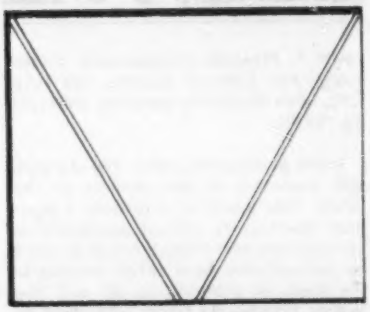
*This report is available for purchase from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

**Single copies of the *Facts for Planning* reports are available upon request from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

LETTERS



Re the article in your Winter Issue (Vol. IV, No. 2), page 2, "ALCOHOL AND THE ARMED FORCES" by James F. Holcomb.

During the mid 1960s, when alcoholism was just barely emerging as a disease, there was a pioneer in the field by the name of Joseph Zuska, M.D. It was Dr. Zuska who fought the Navy, the Admiralty, and the government to bring attention to the needs of the alcoholic servicemen and who founded the Navy program. Upon his retirement in 1973, Dr. Joseph Pursch stepped into large shoes which had been made quite comfortable because of Dr. Zuska's struggles. There is no doubt that Dr. Pursch did an excellent job in carrying on and that Dr. Williams is continuing this magnificent effort. Accurate reporting, however, demands that the credit be placed accurately—Dr. Zuska is the real hero in this epic.

Max A. Schneider, M.D.
President, National Council on Alcoholism of Orange County
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The National Institute on Alcohol Abuse and Alcoholism Clearinghouse, through its information services and publications, supports people and programs who want to do things and are getting things done in the alcohol field.

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If you are working in the alcohol field or are involved with alcohol issues, the NIAAA Clearinghouse can help you get things done. Write for a product listing and order form. The NIAAA Clearinghouse, P.O. Box 2345, Rockville, MD 20852.

BOOK REVIEWS

Lewis F. Presnall. *Occupational Counseling and Referral Systems,* Salt Lake City: Utah Alcohol Foundation, 1981 (257 pp., $9.95).

In the preface the author makes a concise statement of the purpose of the book: "My intent is to provide a practical summary—a sort of handbook or introductory text—which could be used by persons who were either working in the field, or planning to do so." The author achieves his intent, providing an excellent summary of experiential knowledge regarding occupational programs; moreover, the material should serve well as a handbook to those who would work in the field.

The book is divided into three major sections titled The Nature of the Problems in Work Communities, Program Approaches, and Control Systems Administration (which is an awkward title for material on the organization and administration of programs).

The author begins with an introductory chapter on the history of the alcoholism movement as related to the development of occupational programs. The chapter is interesting and worth reading but I was disappointed in that it was only 13 pages long. I felt that the author had so much more he could have told me. The disappointment is somewhat assuaged by the author's frequent historical references throughout the remaining chapters. Thus, each major segment is presented with some historical context.

In Chapter 1 the author sets the stage for the discussion of occupational intervention programs by introducing the concept of behavioral-medical problems, a term intended to include the wide range of problems encountered by occupational counselors (alcoholism, emotional disturbances, marital and family crises, physical handicaps, drugs, physical illness, and legal and financial problems). Chapter 2 is an interesting presentation of the problems associated with determining the prevalence of behavioral-medical problems in work settings. And, while the discussion fails to include the more technical issues related to measuring prevalence, it does provide a wealth of practical wisdom that will be useful to people in the field who are struggling with prevalence considerations.

Chapters 3 and 4 deal more directly with alcoholism. Much of the material in Chapter 3 is a review of the experiences of some of the early occupational programs. Chapter 4 is organized around an interesting concept of "stigmatized vs. non-stigmatized" problems. The author argues that stigmatized problems are surrounded by a mystique which in turn affects how people handle the problems. In essence, everyone participates in denial of stigmatized problems buttressing (or perhaps promoting) the alcoholic's denial behaviors. As a consequence, everyone ignores the problem at great cost to all concerned.

The section on program approaches consists of three chapters that discuss various issues related to the development of intervention programs in occupational settings. Chapter 5 presents the positive and negative features of such programs. The discussion is organized around the comparison of different settings. Chapter 6 introduces a program approach based on a systems model in which the author argues against the practice of foisting "canned programs" on companies and instead suggests that programs must be tailored to meet the unique needs of a company. I had a sense of some confusion in reading this chapter, because in the latter part of the chapter, the author digresses from a discussion of tailoring programs for companies to discuss the subject of fringe benefits and premium costs and claims. Consideration of fringe benefits is fast becoming a critical issue in occupational programs, but seemed to be an afterthought that did not receive the treatment it deserved. Chapter 7 was concerned with a number of details in program organization ranging from selecting a name for a program to resource considerations.

The section on control system administration includes chapters on four topics—staffing, case handling and employees services, training, and review and evaluation. It is likely that these chapters will be of most use to individuals faced with operational responsibilities in an occupational program.

There are several things that bother me about the book. First, it lacks both a subject and author index, a hardship to those who would use it as a handbook. In addition, the style of referencing is inconsistent, and there is no list of references. It seems to me that these problems detract from the quality of the work, and with a little extra effort these could have been corrected.

Is this book good enough to deserve a place on your bookshelf? Of course it depends on what you are looking for. If you want the benefit of the deliberations of someone who has accumulated a great store of personal experience and wisdom related to occupational programs, it is worth your while. If you are looking for a presentation that is organized around a careful documentation of more formal research literature, you will be disappointed. In my opinion it will be a useful reference for program professionals, and it also deserves to be read by those engaged in more formal research and evaluation of such programs.

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DWI Update Introduced in Next Issue

A new column, DWI Update, to be introduced in the Spring 1983 issue of *Alcohol Health and Research World* will keep readers up to date with nationwide efforts to address drinking and driving. Featured in this first column will be Citizens for Safe Drivers Against Drunk Drivers and Other Chronic Offenders, a group dedicated to addressing the human factor in drunk driving problems.

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From The Editor

Last year *Alcohol Health and Research World* asked readers what they thought of the magazine. The comments have been helpful in planning issues and choosing topics on which to focus special attention. We appreciate the time you took to reply to our readership survey, and hope you will find the results as interesting as we did.

Half of those who replied are in counseling and treatment occupations; 16 percent are primarily involved in training; 10 percent are in public information; and about 8 percent are occupational programmers, educators, or researchers. We were pleased to hear that the overwhelming majority of those who replied to our survey planned to renew their subscriptions and found the magazine useful in their work.

You indicated that the most useful types of articles are overviews and program descriptions, and we're working to provide more articles along these lines. You also found our regular departments—Newsnotes, Research Reports, and book reviews—to be useful. It was gratifying that well over half of you share your copies of *Alcohol Health and Research World* with colleagues; nearly three-quarters of you use some of the information in teaching or training, and almost half of you share information from the magazine with clients. Seventy percent have been able to apply the information provided in articles to your own work.

As to subject matter, the most useful special focus topics have been those that dealt with alcohol and youth, family violence, and the NIAAA's Fourth Special Report to the U.S. Congress. Subjects in which you expressed the greatest interest for future coverage were minorities and prevention issues—over 50 percent of those who replied to the survey asked for increased coverage on these topics. Also of high interest were youth, women, and treatment and recovery issues.

We plan each issue almost a year before it is published, and we're working to respond to your interests and concerns. This issue reflects the increasing numbers of contributed articles we are receiving from those of you working in the alcohol arena and related fields. We receive a wide range of thoughtful and well-researched articles on topics related to prevention, treatment, and training. One of our goals is to provide a forum for the publication of programmatic articles.

We also seek to provide you with information on topics that are of high interest to the alcohol field, developing special focus sections that feature both contributed and staff-written articles. Upcoming special focus topics will deal with alcohol and blood sugar disorders and progress in educating healthcare and medical professionals about alcohol and drug abuse issues.

We are anxious to hear your reactions to the magazine, in general or in relation to specific articles and topics.

A Pilot Project on Fetal Alcohol Syndrome Among American Indians

Philip A. May, Ph.D., and
Karen J. Hymbaugh

The Fetal Alcohol Syndrome (FAS) Project of the Indian Health Service was conceived and established in 1979 as a special project for the International Year of the Child.

A team of experts, convened from various programs of the Indian Health Service, felt that fetal alcohol syndrome was becoming a problem among some southwestern Indian tribes in the United States, although the exact nature and extent of the problem were unknown. They designed a comprehensive program to meet the treatment needs of the Indian people as well as to provide training and answers to fundamental research questions about the occurrence of fetal alcohol syndrome in the Indian population.

Experience gained from the project is expected to be of importance in many areas throughout the United States and the world, especially among special subcultures in remote and rural settings. Currently fetal alcohol syndrome is believed to be the second most frequent birth defect in the United States and a leading cause of mental retardation (Streissguth et al. 1980; Eckardt et al. 1981). Since its recognition and diagnosis in 1972-73, it has been the subject of several hundred articles. Most articles fail to describe programs designed to deal with the problem, however, and focus instead on the clinical manifestations of the syndrome. In addition, reporting on the few existing programs has concerned only urban areas and mainly university hospital settings.

The Fetal Alcohol Syndrome Project of the Indian Health Service was developed to serve the American Indian population in New Mexico, southern Colorado, southern Utah, and northern Arizona. This is the geographic area covered by the Albuquerque and Navajo administrative areas of the Indian Health Service.

Author's Note: This project has been supported by Contracts 242-79-0072, 242-79-0081, and 240-81-0022 of the Indian Health Service and the Health Services Administration.

Indian groups served include the Navajos, Apaches, Pueblos, and Utes. In 1980, about 240,000 Indians lived on 26 reservations in the areas.

The socioeconomic status of the southwestern Indian tribes varies, for they represent cultures in various stages of transition (Kunitz and Levy 1981). Many young Indians are upwardly mobile through recent educational and economic gains, but the majority of the individuals and tribes served have little advanced education and few economic assets. Increased resource development, on reservations and in the Southwest, has wrought drastic changes in the social and cultural systems of these tribes.

The land area on which they live is vast—over 150,000 square miles (figure 1). The Navajo reservation alone is larger than the State of West Virginia. Although most travel can be done by car, a small charter plane is required to reach some outlying areas. Within the Indian Health Service system, 11 hospitals and 10 clinics in various locations serve as contact points for the project.

The project was designed with several objectives. Treatment efforts were to emphasize clinical diagnosis. The purpose of diagnosis was to identify the clinical manifestations of FAS in Indian children, develop a treatment plan, refer children to available resources, and prevent further FAS births (table 1). Training of clinicians, outreach workers, and community groups was to focus on the recognition and prevention of fetal alcohol syndrome. Research efforts were designed to assess the incidence and prevalence of the syndrome among Indian children, determine its etiology, and use this information to develop prevention strategies.

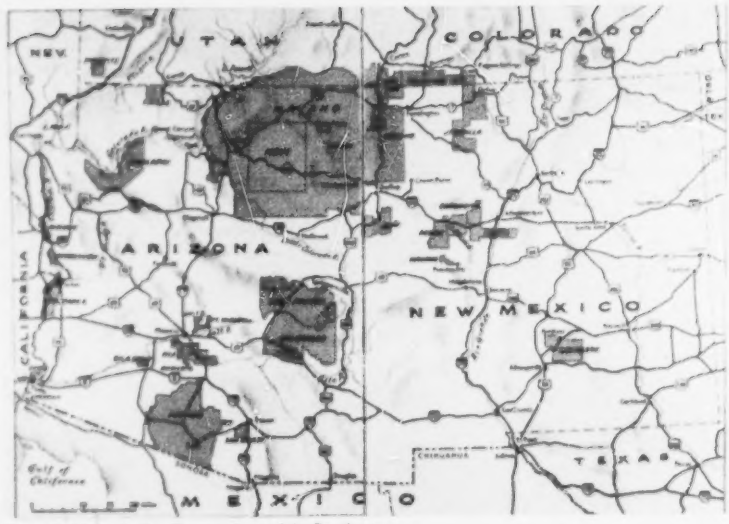

Figure 1. Major Indian Reservations of the Southwest

Staff

The FAS Project staff consists of four regular staff and two consultants: a half time director (Ph.D.), two full-time field coordinators (B.S. and A.A.), a full-time secretary, and two consultant dysmorphologists (M.D.). Teamwork is necessary, as is a thorough knowledge of both the Indian Health Service and the local tribal systems. Two of the staff are Indians from the local area, and all staff have considerable experience in Indian health care on local Indian reservations.

The director oversees all aspects of the project, from training and research to relationships with agencies and tribes and administrative matters. Professional experience in epidemiology, field research, and community health is needed. The director is responsible for much of the training of a variety of individuals, from physicians to outreach workers.

The two field coordinators provide all project services in their assigned geographic area. Training of local outreach workers and citizens is a major duty of the field coordinators. They also coordinate all clinics in their assigned area and keep track of all patients from these clinics. Development of program materials and dissemination of all types of information (pamphlets, posters, articles, and advice) is a constant activity. On one reservation (Navajo) translation of materials into the tribal language has been important, and on all reservations a sensitivity to cultural differences has been vital.

The consultant dysmorphologists, pediatricians who specialize in birth defects and anomalies, are indispensable. In addition to the key role they play in diagnosis of the children, their clinical knowledge has been invaluable. All initial training of clinicians was conducted by the dysmorphologists. The director and field coordinators were apprenticed to the dysmorphologists in these sessions and eventually began to assume most of the responsibility for the training of other target groups. In addition to clinical information, epidemiological, social, and counseling information has been added to the training when appropriate. Although different levels and types of training are used for different groups, the initial core of information was established by the dysmorphologists. The dysmorphologist, with minimal assistance from others, is ultimately responsible for each child's treatment plan.

Treatment

The clinical phase of the project has had several objectives. The committee of experts who established the FAS project felt that it was important to determine and document if FAS children in the Indian population of the Southwest differed clinically from other FAS children reported on in the literature.

Little information exists on the treatment of FAS children, and therefore, thoughtful formulation of treatment plans was a priority. Each treatment plan was to guide the coordination of all treatment and rehabilitation efforts for that child, and to help the child develop to the fullest potential. Once the treatment plan was formulated, the child was to be referred to the parent organization of the project, the Indian Children's Program. A multidisciplinary team of specialists (table 2) would then provide care and treatment, focusing on working with the child's specific problems and working toward eventual habilitation. Whenever possible, treatment and habilitation were to be carried out near the child's home using local resources.

The clinics were conceived as providing a unique opportunity to work with the mothers of these children. Ideally, the mothers, parents, or guardians would attend the clinics with their children, where they would be counseled regarding future pregnancies and care of the existing FAS children. The clinics also were seen as a way to provide specific, on-site training for local clinicians in the diagnosis of fetal alcohol syndrome. Since the diagnosis is a complex and multivariate one, firsthand experience under the supervision of experienced persons was considered vital for local clinicians.

The referral system. The referral system has been critical to the project. Because the area served is vast, the system has to be well conceived and dynamic. As shown in figure 2, a suggested pattern or chain of referrals has been set up that begins with referral in the local community and ends with treatment of the child.

A variety of informative materials have been developed by project staff as aids in referral and other areas of activity. Two Indian-oriented pamphlets were designed to inform the public about alcohol damage to the unborn. One is simple for the less educated; the other is more detailed for those with at least a high school education. Another pamphlet for health personnel describes the services of the FAS Project. Four posters have been used extensively. They relay the simple idea that alcohol can damage unborn babies, by means of themes and motifs from local Indian cultures.

Identification of children with problems is initially made in local communities, clinics, and hospitals. Then referral usually is made to one of four designated professionals at each clinic or hospital service unit—generally physicians (pediatricians or general medical officers) or nurses (clinic supervisors or public health nurses)—using forms with a checklist of the features of fetal alcohol syndrome. The professionals designated to receive referrals have exhibited a particular interest in FAS and have been trained through lectures and clinics by a consultant dysmorphologist from the project. The professionals make tentative diagnoses, help set up clinics, and ensure clinic attendance.

Clinics are generally scheduled when a minimum of four suspected cases of FAS have been identified in a particular location. They are held in the local facilities (hospital or clinic), with the help of a consultant dysmorphologist and one or more FAS Project staff. After chart review, discussion, and 1/2 to 1 hour spent with the patient, a final diagnosis is made, and a specific treatment plan is completed.

In the initial planning of the project, the clinics were not named. One FAS staff member, searching for an accurate, yet sensitive, way to refer to the clinics, began calling them simply "developmental clinics." This name has proved useful and has been consistently used by project and local staff to describe all of our clinics. It is also accurate, for a variety of patients with

Table 1. Goals of the Fetal Alcohol Syndrome Project

Training in the recognition and prevention of FAS and all prenatal alcohol damage. Target groups include—

- Clinicians
- Outreach workers—Public health nurses, alcohol counselors, Headstart teachers, community health representatives, etc.
- Community groups—Tribal councils, schools, local units of government, etc.

Clinical diagnosis of developmentally disabled children who are suspected of having FAS. The purpose of this diagnosis is—

- To determine the clinical manifestations of FAS in Indian children
- To provide a treatment plan that can be carried out to promote each child's optimum development
- To refer children to the Indian Children's Program or other resources for needed services
- To prevent further FAS children.

Research to better define the nature of alcohol damage to unborn Indian babies. Specifically addressed are—

- Incidence and prevalence
- Etiology (medical and social)
- Prevention strategies.

Table 2. Indian Children's Program Multidisciplinary Team

Clinical psychologists
Developmental psychologist
Speech therapists
Developmental pediatrician
Occupational therapists
Physical therapists
Art therapist
Vocational rehabilitation therapist
Educational diagnosticians
Social workers
Recreational therapist
Child psychiatrist

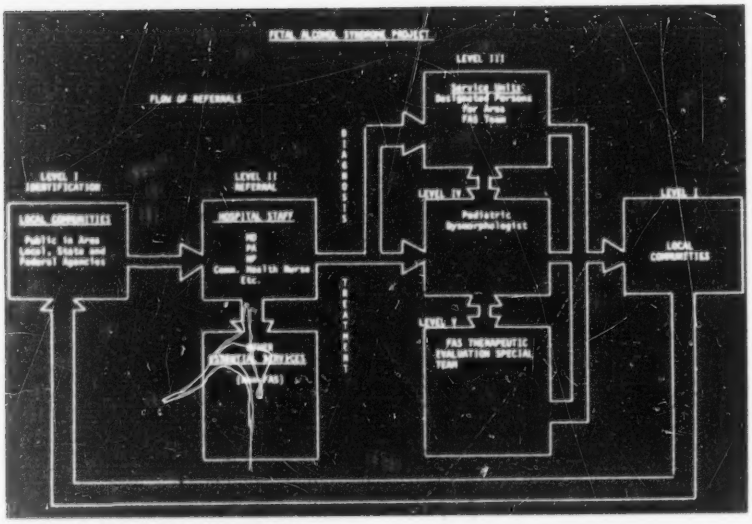

Figure 2. Fetal Alcohol Syndrome Project

diagnoses in addition to FAS and alcohol-related ones have been seen. Regardless of the ultimate diagnosis, any child needing further special treatment or attention receives a treatment plan.

All clinics are directed by a dysmorphologist, and in each a team approach is used. Project staff and local clinic personnel perform support duties such as taking basic measurements (length, weight, and head circumference), giving a Denver Developmental Screening Test, taking a brief medical and social history, and collecting pictures for files. Approximately 1 hour is spent with each child. Several people work together in the initial screening, and one, two, or three staff people generally are present during the dysmorphologist's examination. The main focus of the clinic is obviously on the needs of the child, but an equally important part of each clinic is the training of staff. While the FAS staff learns more from the local staff, about local conditions and patients, they teach the local clinicians some of the finer and more subtle points of the clinical evaluation and habilitation of FAS cases and other birth defects and developmental disabilities. Teaching further cements the bond between project staff and local clinicians.

When the examination summary and treatment plan are typed, copies are transmitted to the child's chart at the local service unit. Copies are also retained by the FAS Project staff and presented to the Indian Children's Program and other appropriate treatment agencies and personnel. Treatment and evaluation is coordinated by the Indian Children's Program, using a multidisciplinary team. The team provides the needed services to the child, refers the child to appropriate resources if they are not available within the team, and teaches local people—both lay and professional—the special techniques needed to care for the child. All treatment is carried out in the local community whenever possible.

From initial referral to followup, the cooperation of various types of professionals and laymen is vital. It is imperative that some flexibility and variability be allowed in the referral system to assure that the particular needs, conditions, and circumstances of the local clinics and people involved are taken into consideration. Project needs must be met in a manner that does not interfere with the work of the local clinic.

It has been vital that the FAS Project serve as the ultimate coordinator and assume ultimate responsibility for treatment of the children. A particular advantage has been the sharing of research data and findings, both from the project and from the literature, with all participants in the referral system.

Clinics. From the first clinic in March 1980 to the end of the project on March 3, 1982, 22 clinics were held in 16 different locations (table 3). More are planned for the future, but await funding.

The average number of children seen per day is 9 or 10. In addition to those recorded in table 3, a number of other children were seen briefly at these clinics for other reasons, such as being siblings of suspected FAS children.

The breakdown of diagnoses indicates that 28.9 percent of all children seen in clinics had the full fetal alcohol syndrome, 15.4 percent experienced a milder degree of damage or fetal alcohol effect, and in another 6.1 percent, findings were "suspicious." For a diagnosis of fetal alcohol syndrome to be made, specific criteria must be met: (1) significant prenatal and postnatal growth deficit, (2) mental deficit, (3) facial dysmorphia, (4) physical abnormalities, and (5) documentation of maternal alcoholism. A diagnosis of fetal alcohol effect (FAE) indicates a milder form of prenatal alcohol damage in which the child has virtually all of the features of fetal alcohol syndrome but in less severe form. A "suspicious" diagnosis denotes that the child meets many of the criteria for fetal alcohol effect, except for insufficient documentation of an abusive maternal drinking history. In general, all FAS diagnostic "labels" are applied conservatively and sensitively, with the major focus being on future therapy.

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In general, the pattern of malformations found in the different Indian groups is quite consistent with that found among individuals of other ethnic groups (Aase 1981).

The remaining 50.4 percent of the children were diagnosed as normal or as having another type of birth defect or anomaly. Other diagnoses included Down's syndrome, hypoparathyroidism, fetal hydantoin syndrome, and Noonan's syndrome. Other types of developmental problems were referred to the clinics so that the dysmorphology services could be used. Some of these referrals were made for anomalies similar in appearance to FAS, but others were totally unrelated and were made simply because the service was needed.

The clinics have successfully provided needed diagnostic services for 230 children. They have been well attended, indicating the success of the referral system. The finding that 44.3 percent of the children referred are definitely suffering from some degree of prenatal alcohol damage is another indicator of a successful referral system. The clinics also seem to have helped create and maintain an interest in a variety of developmental disabilities. Providing an underserved area with a needed specialty has been very gratifying to all.

Training

The training of clinicians and outreach workers primarily was designed to aid them in the referral of suspect children for diagnosis and treatment and to use their knowledge in preventive counseling with clients. Major hopes for prevention, however, were focused on the community training sessions involving tribal councils, schools, and local government units. Since fetal alcohol syndrome is a preventable birth defect, educating people of all ages in the community about FAS was considered vital. If people could be made aware that alcohol causes developmental defects, primary prevention would be possible.

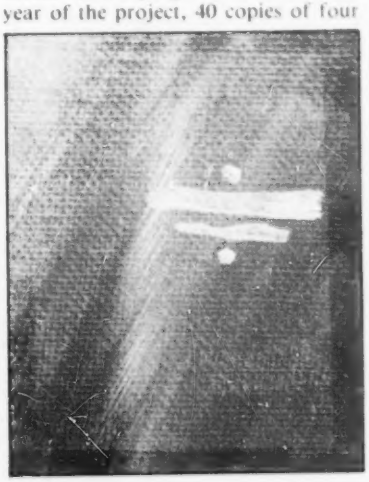
From the beginning of training in January 1980 to March 3, 1982, 232 training sessions were held. In these sessions, 11,123 people were trained by three FAS project staff members and two consultant dysmorphologists (table 4). Of the 11,123 persons trained, 9.3 percent (1,033) were clinicians, 26.7 percent (2,978) were outreach workers, and 63.9 percent (7,112) were community members, primarily students. The average number of people trained per session was 48.

Participating physicians, nurses, pharmacists, and physician assistants generally receive 2 to 2.4 hours of continuing education credits. Community training sessions are less detailed than clinical sessions and rely more heavily on films and discussion than on lecture. In remote parts of the Navajo reservation, sessions often are conducted in the Navajo language through a community interpreter or the Navajo field coordinator. Community sessions are uniformly well received by young and old and do not meet with the resistance generally associated with alcohol-related presentations. In fact, the FAS presentation usually allows for discussion of other, normally controversial alcohol-related topics and issues in a constructive and relaxed atmosphere.

In addition to formal training sessions, posters and pamphlets designed by the program staff increase exposure to fetal alcohol syndrome information. Approximately 7,000 posters and 55,000 pamphlets have been distributed. Films have been important media for the program. In the second year of the project, 40 copies of four different training films on FAS have been continuously on loan to interested parties, such as parent-teacher groups, prenatal classes, health organizations, and schools.

Other materials designed by the program staff that have been widely distributed include a bibliography on fetal alcohol syndrome and related issues; a resource guide listing films, slides, posters, pamphlets, and other FAS materials; and a training guide. All materials have been distributed among national as well as local Indian groups to assist people in starting their own information sessions, campaigns, and systems.

The training sessions and educational materials continue to be enthusiastically received.



Research

Research efforts were designed to expand knowledge about fetal alcohol syndrome among Indians. At present, the literature on the incidence and prevalence of fetal alcohol syndrome is very scarce. Estimates of incidence exist only for the United States (Streissguth et al. 1980), Sweden (Olegard et al. 1979), and France (Dehaene 1977). In most cases the estimates provided are only rough; detailed, systematic prevalence studies are needed. No reliable estimate exists for Indians (see Aase 1981). Specific goals of the project were to establish incidence and prevalence figures for the entire population and for individual tribes, to understand the etiological factors involved in the development of fetal alcohol syndrome, and to use this knowledge to devise prevention strategies.

The initial research results, although still incomplete, show that the incidence of fetal alcohol syndrome varies among reservations. On some, no fetal alcohol children have been found, while on others there are children with severe problems. The wide variation in patterns of drinking and alcohol-related problems among the different tribes has been described by Levy and Kunitz (1974) in the social science/epidemiological literature on Indians and alcohol use. Tribes with a loose, band-level social organization tend to have a higher incidence of alcohol-related problems than do those with a strict, highly structured tribal organization. In general, FAS distribution follows this pattern, with the more highly structured tribes having the fewest drinking mothers and lowest incidence of fetal alcohol damage (May, in press). The incidence of FAS among southwestern Indians may be higher than that reported in the United States generally. One out of every 1,500 to 2,000 babies born in the U.S. is believed to have FAS, while the incidence of other adverse consequences during pregnancy is estimated to be 20 times that rate, according to Assistant Secretary for Health Edward N. Brandt, Jr., M.D., in Congressional testimony in September 1982. Some of the reservations in the project have a significantly higher incidence of FAS than the general United States population, which cancels out the effect of lower incidence reservations and, therefore, makes the overall incidence slightly higher.

A research finding of major importance is the prevalence of multiple FAS or FAE children being born to one mother. Among the mothers with affected children, 22.6 percent have produced more than one damaged child (average 2.36 per multiple producing mother). This appears to be very unusual, for little documentation of this exists in the literature on the general population. Only one case of FAS-affected twins has been found among mothers in our project. It is important to calculate incidence in two ways: the proportion of damaged babies produced per all births; and the proportion of all mothers producing alcohol-damaged babies. These figures will provide more specific indicators of risk and better insight for prevention.

Ostracism of the drinking mother may play a role in the production of multiple FAS babies. In many southwestern tribes, few women drink. Alcoholic women therefore are not tolerated and are frequently left out of regular social interaction. The consequence is almost total lack of social control over their behavior. These women generally migrate to border towns where their only friends and associates are other alcoholics—a setting where there is little stigma attached to the production of multiple FAS children.

Other data indicate that mothers who produce alcohol-damaged children are at high risk in the social sense. A high percentage of the FAS children are in foster placement (see table 3), a high percentage of the mothers are deceased (21 percent), and most mothers have extensive clinic records for alcohol-related problems such as accidents, trauma, and alcohol withdrawal.

Table 3. Diagnosis of patients in developmental clinics by sex and foster placement, March 1980 to March 3, 1982.

Diagnosis	Total	Percent	Male	Female	Foster Placement	Percent
FAS	66	28.9	35	31	48	(72)
FAE	35	15.4	24	11	26	(74)
Suspicious	14	6.1	5	9	10	(71)
Other/Not FAS	115	50.4	66	47	64	(57)
Total	130	100	130	98	98	(65)

Note: 24 clinic days; average 9.56 patients per clinic day.

Table 4. People trained by the Fetal Alcohol Syndrome Project by occupation, January 1980-March 3, 1982.

Occupation	Number	Percent
Clinicians	1,033	9.3
Outreach workers	2,978	26.7
Community persons	7,112	63.9
Students (h.s. or below)	(6,322)	(56.8)
Others	(790)	(7.1)
	11,123	100

Note: Average (mean) per session = 47.9 Clinical and outreach worker sessions are generally smaller than this average.

Conclusion

This paper describes a comprehensive program designed to study and deal with the problem of fetal alcohol syndrome among Indians in the southwestern United States. Training and education, clinical diagnosis and treatment, and research and prevention are all components of this project. Each part of the project has been designed to allow for a variety of complementary efforts.

The project depends highly on interaction and cooperation among community and medical interests. Although the project described here can be used elsewhere with success, it must be innovatively, flexibly, and humanistically adapted to local circumstances. In other words, this system is a guide that directs and focuses efforts. It can and should be varied from time to time to meet the needs of local health providers, communities, and other cooperating interests.

The services of such a project can easily be offered to communities in a sensitive and nonthreatening way. These services seem to help build a relationship that spans the gap between the project and local concerns and creates a new awareness of FAS and of developmental disabilities in general.

It is unlikely that a program omitting any of the strong training, clinical, or research effort would be nearly as effective. Results from the program serve as evidence that it works. A vast number of people have been trained. Many children have been referred and diagnosed appropriately. And finally, the research effort has provided new, exciting, and accurate information that will aid in future understanding, intervention, and prevention.

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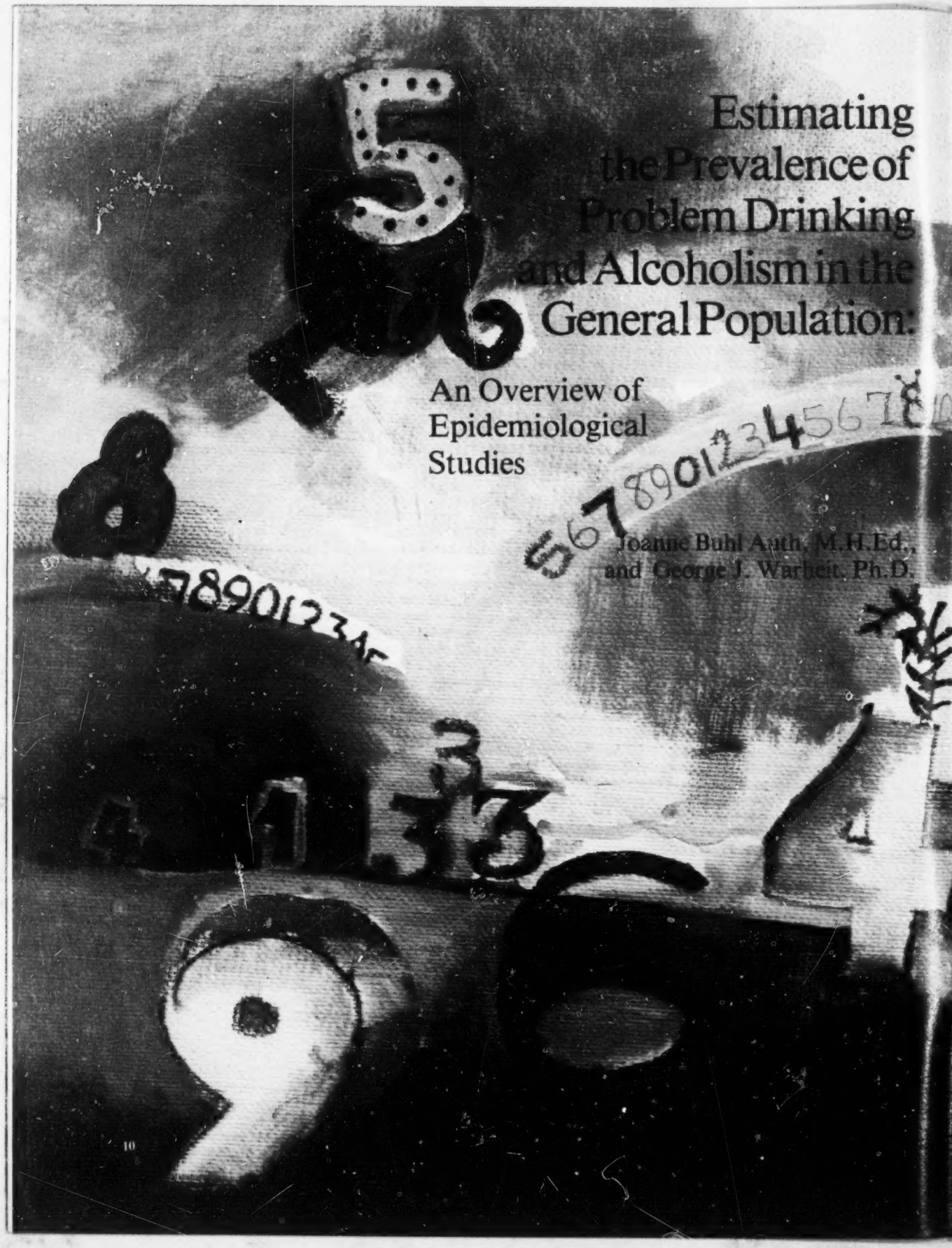

Estimating the Prevalence of Problem Drinking and Alcoholism in the General Population:

An Overview of Epidemiological Studies

Joanne Buhl Auth, M.H.Ed.,
and George J. Warheit, Ph.D.

Alcohol abuse and its consequences represent costly personal and societal problems. It has been conservatively estimated that, in 1977 alone, alcohol-related problems in the United States accounted for direct or indirect expenditures of $49.4 billion. These costs were attributable to lost production, health and medical costs, motor vehicle accidents, violent crimes, social responses, and fire losses (Cruze et al. 1981). In its *Fourth Special Report to the U.S. Congress on Alcohol and Health*, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated that alcohol is a factor in 10 percent of all deaths in the United States and that about 1 in 10 adult drinkers is likely to have a drinking problem or to become an alcoholic (NIAAA 1981). These figures illustrate the magnitude of the problem and underscore the importance of allocating intervention and treatment program money as cost-efficiently as possible. This article is intended to assist human service agency planners in selecting methods for obtaining reliable estimates of alcoholism and problem drinking prevalence in their communities.

This review focuses on research that has explored the patterns and consequences of alcohol consumption among adults in the United States. Estimates of prevalence rates for alcohol abuse and alcohol-related problems in the general population have been derived primarily from four data sources: extrapolations from liver cirrhosis mortality statistics; per capita consumption of alcoholic beverages as determined from tax records; agency and institutional reports of patient or client contacts; and field surveys of adults in community settings.

The following sections include descriptions of these estimation methods and examples of studies that used them. The relative strengths and weaknesses of each method are examined. However, the emphasis is on the community survey, which is currently the most popular technique for characterizing and estimating the number of adult problem drinkers in the general population.

Although precise comparisons of findings from the various studies using one or more of the estimation methods would show many contradictions, a brief summary of major conclusions reveals general agreement concerning high risk groups for problem drinking and alcoholism.

Mortality from liver cirrhosis. One of the first systematic methods for estimating the number of alcoholics in the United States was developed following the observation that liver cirrhosis deaths decreased much more dramatically than did general mortality rates during and, for a period of time, following Prohibition. This led Jellinek and his colleagues to devise a formula $(A = (\frac{PD}{K})R)$ for estimating the total number of alcoholics alive in a given year (WHO 1951). The number of alcoholics (A) was determined by multiplying the percentage of liver cirrhosis deaths attributable to alcoholism (P) by the number of reported deaths from liver cirrhosis in the same year (D), and dividing that number by the percentage of all alcoholics with medical complications who died of cirrhosis of the liver (K). Multiplied by the ratio of all alcoholics to alcoholics with medical complications (R), the resulting total was an estimate of the number of alcoholics one might expect to find in the area being studied.

The "Jellinek formula," as it came to be known, was only one facet of the extensive theoretical and methodological work reported by Jellinek and his colleagues (Jellinek 1942, 1947, 1960; Jolliffe and Jellinek 1942; Jellinek and Keller 1952; Keller and Efron 1958). Nonetheless, it has been one of the most widely cited, despite the questions and criticisms surrounding its derivation and use. The misinterpretation and misapplication of the formula may have arisen from the relative inaccessibility of its full description as first published (WHO 1951). Argeriou (1974) very helpfully retrieved and presented the Jellinek formula as it appeared in its original form, and an article by Popham (1956) also clarifies some of the mysteries surrounding this estimation approach.

As originally devised, the Jellinek formula estimated the number of alcoholics with complications (Jellinek 1942). This was later adjusted to reflect the rates per 100,000 of the drinking age population of alcoholism with or without complications (Jellinek and Keller 1952; Keller 1955, 1975; Popham 1956). Several problems are apparent regardless of which variation of the formula is employed. First, it enumerates primarily persons whose drinking behaviors result in the negative consequences most often associated with heavy and prolonged alcohol use. Changes in rates may actually reflect excessive drinking in the preceding 15 or 20 years (Jellinek 1947). It also assumes that new drinkers are equally susceptible to the problems encountered by earlier drinking populations. Moreover, the rates reported must be considered tentative rather than absolute, since there are inconsistencies in the acceptable definitions of the formula's components (Argeriou

1974; Seeley 1960), as well as in the varying means by which medical conditions and autopsy results are reported (Bailey 1967; Keller 1975; Popham 1956; Room 1972). Furthermore, the formula was intended for application to large regions or national populations in excess of 300,000 (Bailey et al. 1965). The chance of estimation error tends to increase as the size of the population on which it is based decreases.

Jellinek himself (1959) readily conceded his own dissatisfaction with the estimation method because the values of P, K, and R required periodic revision. In particular, Jellinek cited the problems associated with the reporting of statistics on alcoholic complications. "Generally, I would not be in favor of the continued use of my formula, nor any modification of it, as there are too many fluctuating factors present. Much more to be desired is a new basis, and particularly actual field surveys," he said.

In spite of its acknowledged limitations, the use of Jellinek's formula has mushroomed beyond its original intent. Its fundamental basis was sound at the time it was originated. Its uncritical use today must be questioned, however. For example, the earlier treatment of complications from alcohol abuse may be altering the previously observed associations between cirrhosis deaths and alcoholism rates. The Jellinek formula has served a purpose in the past. It should no longer be considered a primary or universally valid approach for estimating alcoholism or problem drinking prevalence.

Per capita consumption. A second method used to estimate the prevalence of alcohol problems and probable alcoholism is based on the assumption that heavy alcohol use is related in a predictable way to the mean beverage alcohol consumption of a population as determined from sales reports (NIAAA 1971). This implies that the number of heavy drinkers could be computed for any population group for whom the mean alcohol consumption level is known. The procedure has been popular, since it is a relatively simple one.

A widely cited per capita consumption model was developed in France by Ledermann (1956). Miller and Agnew (1974) define the Ledermann model as "an attempt both to describe and predict the consumption of alcoholic beverages in homogeneous populations." The model assumes that alcohol consumption is lognormally distributed in homogeneous populations and, therefore, that "the frequency distribution of alcohol use can be calculated from estimates of the mean annual consumption of alcohol for any homogeneous population of drinkers." Furthermore, it presumes that one is able to make predictions about changes in the number of heavy drinkers by noting changes in mean consumption levels reported. Miller and Agnew cite several weaknesses in the Ledermann theory's applicability, validity, and predictability, particularly if the term "heavy drinkers" is construed to mean "alcoholics." They suggest the need for further testing of the model.

Duffy and Cohen (1978, 1980) have also criticized the Ledermann model. They in turn have been criticized by Skog (1980*a*), who contends Ledermann is correct about the lognormal distribution of alcohol consumption (1980*b*). DeLint (1978) also defends the model while conceding it might be possible to improve it by modifying the constants used. DeLint and Schmidt (1971) have reported a close relationship between per capita consumption among drinking-age adults and liver cirrhosis mortality in the United States and in other countries. They found that, regardless of the arbitrary level of alcohol consumption designated as alcoholic, "the prevalence of alcoholism is invariably determined by the overall level of consumption in the population." Moreover, their review of regional studies showed that expense and availability of alcoholic beverages are related to corresponding fluctuations in liver cirrhosis mortality. DeLint and Schmidt concluded that high volume consumption in a population remains one of the most reliable predictors of probable alcoholism.[1]

A similar conclusion was reached by Cartwright, Shaw, and Spratley (1978*a*, *b*) who compared per capita consumption, drinking patterns, and alcohol-related problems with survey data gathered from 1965 to 1974. They found support for the Ledermann-based theories that increases in mean consumption result in an increase in the percentage of drinkers who fall into the high volume consumption categories, and that a rise in consumption is likely to be accompanied by a rise in alcohol-related problems.

Fitzgerald and Mulford (1978) compared levels of alcohol consumption, as reported by representative samples of adult residents in two epidemiologic surveys conducted in Iowa in 1958 and 1961, with official records of alcohol sales during those years. Survey estimates of annual per capita consumption were substantially lower—by a ratio of 1 to 3—than Iowa sales records indicated. These differences persisted despite adjustments for seasonal fluctuations.

The findings did not support an assumption of the Ledermann model, i.e., that risk of alcoholism is concentrated among heavy drinkers. Fitzgerald and Mulford (1978) noted that "if alcoholism is defined as something more than a physiological complication, total consumption is an inadequate predictor of alcoholism." And they suggest that "whether the increase (in consumption) is due to quantity or to frequency is an important question in anticipating whether the consequences of that increase are immediate social problems or delayed health problems."

The social correlates of a per capita consumption approach to estimation were addressed by Donnelly (1978) who utilized the Mental Health Demographic Profile System (MHDPS) items to "predict" liquor store sales, cirrhosis death rates, and arrests for

[1]This does not necessarily mean that high volume drinking is always accompanied by high rates of problem drinking. In the *First Special Report to the U.S. Congress on Alcohol and Health* (NIAAA 1971), cross-cultural studies are cited that suggest the reverse can also occur; that is, countries ranking fairly low in apparent consumption of alcohol may evidence high rates of alcoholism.

drunkenness and DWI for the 67 counties in Pennsylvania. One of his findings was that alcohol sales were correlated (.50) with alcohol-related arrests and (.45) with cirrhosis deaths. Higher income, occupational status, educational level, and degree of urbanization as well as the presence of high proportions of minority groups were also correlated with per capita sales. The high correlation found among sociodemographic factors and alcohol-related arrests and death rates suggests, however, a possible problem with use of consumption models; socioeconomic factors may "dilute" or lessen the validity of these models.

Another problem with per capita consumption approaches is their reliance on official tax records, which are not always accurate indicators of per capita alcohol consumption among residents of a geographic area. Residents of popular tourist and convention cities and communities adjacent to "dry" areas or to States with higher alcohol taxes are likely to be assigned artificially high rates of alcohol consumption (Room 1972).

Rates in clinical populations. Consequence-based estimates of alcoholism have generally been obtained from treatment agency records, hospital admission data, and reports from private physicians. One of the first U.S. surveys was reported by Riley and Marden (1946), who interviewed every 10th physician in New Jersey in 1945 (N = 455). An excellent international review of reporting-agency surveys is provided by Edwards (1973).

Alcohol problem rates based on statistics from treatment or rehabilitation centers and institutions must be interpreted with caution because they often reflect socioculturally skewed admissions policies and contain multiple counts owing to the revolving door phenomenon; perhaps most problematic is that these facilities often treat only the most seriously dysfunctional alcoholics. Similarly, estimates derived from family physicians and psychiatrists in private practice may seriously underestimate the actual number of patients being treated for alcohol problems (Lipscomb 1966). While data from public and private sector health care providers can be useful, prevalence statistics based on such information cannot accurately be extrapolated to the general population.

The community survey approach. The inadequacies of the preceding methods in providing estimates of alcohol abuse gave impetus in the 1940s to epidemiologic field surveys designed to collect data on drinking practices among noninstitutionalized populations by questioning representative samples of adults in the general population. Household interviews can provide scientifically valid and reliable information if sampling techniques are sound and data-gathering instruments are carefully designed and administered. Furthermore, indirect approaches are usually best suited to use with very large population bases, but targeted field surveys can pinpoint alcohol service needs of special groups or small areas.

Community surveys of drinking practices typically include additional questions designed to obtain sociodemographic characteristics of the respondents (sex, race, age, marital status, education, occupation, income, religion, and ethnic background) as well as physical health data. Those questions, along with alcohol-related items, provide information about nondrinkers as well as drinkers with a specificity unmatched by any other methodology. This enables the investigator to compare and contrast social and demographic correlates of varying levels of self-reported alcohol consumption in addition to assessing attitudes about drinking among persons who give evidence of different patterns of drinking behavior. High risk groups can be identified, and "hidden" problem drinkers who live in protective environments may also be discovered and counted.

While the community survey approach avoids some of the theoretical and methodological shortcomings of the other approaches, it has several of its own. For example, defining "abuse" or "alcohol problems" is a complex issue that has not yet been fully resolved, either among researchers or among the individuals they study (Popham and Schmidt 1978). Haberman (1970), in an analysis of interviews with 1,408 adults in New York City, speculated that "denial of their drinking by those respondents who either identified drinking with drunkenness or excluded wine or beer from what they meant by drinking seems to have been a major source of bias in responses to the survey." Similarly, self-reports of alcohol consumption tend to reflect recent drinking patterns and therefore may be strongly influenced by seasonal variations; for example, more beer drinking occurs during the summer months (Fitzgerald and Mulford 1978).

Although researchers are often surprised to discover that respondents are remarkably uninhibited when asked to describe their drinking behavior and its consequences (Manis and Hunt 1957), there is also the commonly acknowledged problem of minimized and discrepant reporting of alcohol consumption, especially among known heavy drinkers (Bailey et al. 1966; Garrett and Bahr 1974). This is particularly true for males (Garrett and Bahr 1974). Accordingly, most of the more recent epidemiologic surveys have used multidimensional definitions of alcohol abuse or potential problem drinking rather than relying on simple quantity and frequency measures.

Factors frequently considered when estimating the prevalence of problem drinking include consumption patterns, social context of drinking, reasons for drinking, self-appraisal of drinking behavior, environmental/cultural considerations, and physical/social consequences. Characteristically, individual questions related to these various dimensions have been grouped into indices or scales and tested for validity and reliability. Table 1 identifies some of the most common indices and scales; the references provide specific sources from which further information can be obtained.

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Table 1. Examples of indices/scales/measures used in community surveys

Name of measure	References
Quantity-Frequency (Q-F) Index of Alcohol Consumption	Straus and Bacon (1953) Maxwell (1958) Mulford and Miller (1960*a*) Celentano and McQueen (1978*a*) Garrett and Bahr (1974)
Frequency-Quantity (F-Q) Index	Knupfer and Room (1964)
Quantity-Frequency-Variability (Q-F-V) Index	Cahalan and Cisin (1968) Cahalan et al. (1969) Barnes and Russell (1978) Wechsler et al. (1978)
Volume-Variability (V-V) Index (or Volume-Maximum)	Cahalan et al. (1969) Room (1972)
Scale of Social Complications Special Stress on Drinking Anxiety About Drinking	Straus and Bacon (1953)
Iowa Scale of Definitions of Alcohol	Mulford and Miller (1960*b*)
Iowa Scale of Preoccupation With Alcohol	Mulford and Miller (1960*c*)
Trouble Due to Drinking	Mulford and Miller (1960*c*)
Difficulties Due to Drinking	Bailey et al. (1965)
Indices of Alcohol Problems (1) Excessive Drinking (2) Concern About Own Drinking (3) Interpersonal and Other Problems (4) Addiction and Dependence	Clark (1966)
Problem Indexes of Social Consequences Dependence Excessive Intake	Knupfer (1967)
Indicators of Drinking Problems	Room (1972)
Measurement of Escape Drinking	Cahalan and Cisin (1968) Celentano and McQueen (1978*a*)
Current Problem Drinking Typology	Cahalan (1970)
Social Consequences Tangible Consequences Problematic Intake	Cahalan and Room (1974)
Social-Psychological Risk	Cahalan (1970)
Index of Uncontrolled Drinking and Loss-of-Control Measure	Celentano and McQueen (1978*a*) (from Mulford)
Absolute Alcohol-Quantity-Pattern Index	Little et al. (1977)

History of Surveys

In 1946 a national survey was conducted for Rutgers University by the National Opinion Research Center of the University of Denver "to delineate for the first time . . . the social patterns of drinking in the U.S. . . . based on a scientifically prepared sample of the total population. . . ." (Riley and Marden 1947). Although the study used quota sampling, which allowed substitution for unavailable respondents, it remains a pioneering effort in the epidemiology of problem drinking.

Surveys conducted in the 1950s and 1960s of alcohol consumption among adults in the household population included an assessment of drinking behaviors and attitudes in the State of Washington (Maxwell 1952, 1958) that employed a Quantity-Frequency (Q-F) index adapted from earlier work by Straus and Bacon (1953).

In a series of papers entitled "Drinking in Iowa," Mulford and Miller (1959, 1960*a, b, c, d*) reported results of a 1958 study based on a stratified quota sample representative of Iowa's adult population. Interviews administered to 1,185 respondents assessed variables such as age, sex, education, religion, self-concept, and definitions of "appropriate" alcohol use as related to prevalence and extent of drinking and measured by a Q-F index. Also assessed were factors thought to be highly symptomatic of problem drinking.

In 1961, a replication study (N = 1,213) of Mulford and Miller's earlier work evaluated the validity and reliability of their findings. Comparisons were also made between the survey data and an availability sample of 424 hospitalized alcoholics (Mulford and Miller 1963*a, b*). These two Iowa surveys were preliminary to a nationwide study carried out in 1963 (N = 1,515)

that provided, for the first time, extensive sociodemographic correlates as well as regional estimates of variations in drinking behavior in the United States (Mulford 1964).[2]

The early sixties were unquestionably fruitful in terms of substantive contributions to our knowledge about drinking practices in this country. A 1960-61 survey of 3,539 adults conducted for the National Council on Alcoholism was designed to identify alcoholics, to compare them with the adult population as a whole, and to compare the identified alcoholics and a matched sample of nonalcoholic controls (Bailey et al. 1965). A major methodological weakness of the survey was the selection of any available adult in the selected households to answer the questions about other family members. Furthermore, "probable alcoholics" were determined not only by these first or secondhand responses but also on the basis of interviewer observations, which were in some instances judged to be more reliable estimators of alcoholism than the respondents' answers. A second stage of the study was conducted in 1963 and 1964; 442 reinterviews were obtained with identified probable alcoholics, their spouses, and nonalcoholic controls (Bailey et al. 1966).

The California Drinking Practices Studies were also conducted in the 1960s. Building on earlier work in Berkeley, a 1962 San Francisco survey had two primary objectives: the refinement of classification procedures used to measure alcohol consumption (controlling for age, sex, and socioeconomic status) and the evaluation of the significance of drinking patterns as part of social roles (Knupfer and Room 1964). In 1964, a subsample of 970 of the original 1,268 respondents was reinterviewed. Emphasis was placed on locating persons previously identified as heavy drinkers. However, the use of interviews with respondents and/or their spouses, and the subsequent weighting of responses intended to preserve the representativeness of the sample, produced somewhat confusing numbers (Clark 1966; Cahalan 1970; Knupfer 1967; Room 1972). It is important to note, however, that the followup survey does represent one of the first reported epidemiologic efforts to obtain longitudinal data on drinkers.

The San Francisco studies served as groundwork for an ambitious national survey funded by NIMH—the American Drinking Practices (ADP) survey conducted in 1964-65. Cahalan and Cisin (1968) and Cahalan, Cisin, and Crossley (1969) reported findings based on 5,321 weighted interviews (2,746 actual respondents) in households considered representative of the total U.S. adult population. The ADP established baseline data for adults 21 years old or older living in the nine census regions of the continental United States and belonging to various sociodemographic-economic subgroups. The ADP survey provided one of the most exhaustive explorations and detailed reporting of alcohol use and abuse in the United States. In addition to the measurement of alcohol consumption, the behavioral correlates of drinking, drinking effects and problems, reasons for drinking, and the personality attributes of drinkers were probed.

In 1967, a subsample of 1,359 of the original respondents was reinterviewed (Cahalan 1970). The focus was on problems related to drinking; therefore, a disproportionately large number of drinkers were selected. All reinterviews were weighted to represent their numbers in the initial survey. Because it was apparent from earlier studies that males under 60 were at special risk for developing problems caused by drinking (Mulford 1964; Bailey et al. 1965; Cahalan et al. 1969; Mulford and Miller 1960*d*), Cahalan and his colleagues designed a third-stage study of drinking practices of males 21 to 59 years of age. Data from interviews with 583 males were combined with data obtained from a 1969 national sample of 978 males. The 1969 interviews provided especially detailed information on current (within the preceding 3 years) and lifetime drinking problems (Cahalan and Cisin 1976; Cahalan and Room 1974).

Even more sophisticated in methodology was a San Francisco survey conducted in 1967-68. Designed to complement the national studies by exploring in greater detail "the association between local environmental characteristics and drinking behavior," a strict area probability sample of white males 21 to 59 years old was interviewed, using an extensive survey instrument (Cahalan and Room 1974). A 1972 followup of the sample (primarily mailed questionnaires) yielded longitudinal data on 615 of the original 786 respondents. The followup permitted analyses of drinking behavior changes that had occurred between 1968 and 1972 (Clark and Cahalan 1976).

Cross-sectional surveys of drinking practices continued to flourish in the 1970s. A grant from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and contracts from the National Institute of Mental Health (NIMH) Center for Epidemiologic Studies helped support a project in Washington County, Maryland, conducted from 1971 to 1974 (Celentano and McQueen 1978*a*, *b*). Responses from household interviews with about 2,700 adults enabled the investigators to compare prevalence rates of problem drinking based on five commonly used indices. Furthermore, the rates derived from these direct measures were compared with prevalence rates derived from two indirect approaches, the Jellinek formula and the Ledermann consumption model. The researchers found that although the survey and indirect methods estimated similar rates of alcoholism (about 5 percent), "the extent of overlap of cases accounted for by each method was quite low" (Celentano and McQueen 1978*a*).

Western New York was the site of a 1975 survey in which data from interviews with 1,041 adults were used to estimate the extent of heavy drinking in the Buffalo metropolitan area (Barnes and Russell 1978). The findings were compared with 1964-65 ADP

[2]It is interesting to note that the authors observed discrepancies between drinking habits reported by respondents interviewed by "abstaining" versus "drinking" interviewers. The differences were similar in both of the Iowa surveys as well as in the 1963 national survey.

Table 2. Surveys of adult drinking practices

Year(s) of study	Reference(s)	Site	Sample size	Sampling procedures
1946	Riley and Marden (1947); Riley et al. (1946)	U.S.	2,677	Quota
1951	Maxwell (1952, 1958)	Washington State	478	Stratified sampling technique
1958	Mulford and Miller (1959, 1960*a*, 1960*b*, 1960*c*, 1960*d*, 1963)	Iowa	1,185	Stratified, quota sampling to represent adult noninstitutionalized population
1960-61 (Stage A)	Bailey et al. (1965)	Washington Hts. Health District (NYC)	3,539	Probability; two-stage cluster design of dwelling units
1963-64 (Stage B)	Bailey et al. (1966)	Washington Hts. Health District (NYC)	442	Subsample of respondents to first survey
1961	Mulford and Miller (1963)	Iowa	1,213	Same as 1958 Iowa survey
1962 (T-1)	Knupfer and Room (1964); Room (1972)	San Francisco	1,268	Area sampling, stratified tracts and to block level; random selection of adults in HH
1964-65 (T-2)	Clark (1966); Room (1972); Knupfer (1967)	San Francisco	970	Subsample of respondents to first survey, with oversampling of drinkers
1963	Mulford (1964)	U.S.	1,515	Modified random; multistage area probability to block or segment level; quotas on sociodemographics
1964-65 (ADP)	Cahalan and Cisin (1968); Cahalan et al. (1969); Cahalan (1970); Cahalan and Cisin (1976)	U.S. (48 States)	2,746	Randomly predesignated adults in random HH in 100 primary sampling unit areas
1967 (ADP followup)	Cahalan (1970)	U.S. (48 States)	1,359	Subsample of respondents to first survey with oversampling of drinkers
1967 and 1969	Cahalan and Room (1974); Cahalan and Cisin (1976)	U.S. (48 States)	583 (1,561) 978	Subsample of male respondents 21 to 59, from first survey
1966	Gallup (1966)	U.S.	1,500 (approx.)	Replicated probability to block level or township segments
1967-68 (T-1)	Clark and Cahalan (1976); Cahalan and Room (1974)	San Francisco	786	Strict area probability; white males, age 21 to 59
1972 (T-2)	Clark and Cahalan (1976)	San Francisco	615	Primarily mailed questionnaire to respondents to first survey
1971-74	Celentano and McQueen (1978*a*, 1978*b*)	Washington County, Maryland	2,746	Systematic sample of HH; random selection of adults in HH
1974	Gallup (1974)	U.S.	1,500 (approx.)	Replicated probability to block level or township segments
1975	Barnes and Russell (1978)	Western New York State (Buffalo SMSA)	1,041	Stratified random
1975	Wechsler et al. (1978)	Boston SMSA	1,043	Area probability sample housing units; random selection of adults in HH
1977	Gallup (1977)	U.S.	1,500 (approx.)	Replicated probability to block level or township segments

[1]Heavy drinking was determined by most surveys on the basis of some combination of quantity-frequency of alcohol consumption; see references for specific indexes used. Percentages in brackets have been computed from available data and should be interpreted as close approximations.

[2]Percentages were determined for this sample on three indexes: F-Q (frequency-quantity), V-V (high volume - high maximum), and FI (Index of Frequent Intoxication).

[3]Cities of more than one million population only.

[4]Problem drinking criteria varied considerably among surveys; see references for descriptions of indexes.

Percent abstainers			Percent heavy drinkers[1]			Percent "problem" drinkers[4]		
Total	M	F	Total	M	F	Total	M	F
35	25	44						
37	24	49						
40	31	49	8.9	14.0	3.9	2.9	5.0	1.0
						1.9	3.0	1.0
41	33	48	6	[10]	[3]	1.3		
24	19	28	21	29	13(F-Q)[5]			
			14	22	8(V-V)			
			7	12	4(FI)			
			3.1	5.2	1.8	6.2	9.5	4.0[5]
						9.2	15.0	5.2[5]
29	21	37	8	13	3	7.0	13.0	1.0
32	23	40	12	21	5	6	10	3
			(18	34	5)[5]			
						9	15	4
							20	
35	30	39						
26	19	32	15	26	6	14	20	9(ED)[6]
						8	13	4(HED)[6]
						15	20	10(LC)[6]
32	23	39						
14	11	16	24	39	11			
17	13	20	23	38	12			
29	23	35						

Note: For purposes of comparison, the U.S. Bureau of Census (1979) computes the following estimates, based on the Jellinek formula for 1975:
4.2 7.3 1.3

[5]Analyses of the survey data varied in the reports by Knupfer and Clark.
[6]Percentages were determined on three indexes: ED (escape drinkers), HED (heavy escape drinkers), and LC (loss of control drinkers).

national data as well as with ADP rates for the Middle Atlantic census region, of which New York is a part. This comparison showed that the proportions of heavy drinkers in the Buffalo SMSA were higher then the nationwide estimates and most closely resembled ADP figures for the Middle Atlantic region.

Also in 1975, a probability sample of 1,043 adults was interviewed in Boston and categorized into drinking subgroups (Wechsler et al. 1978). Social correlates of drinking behaviors were described and rates compared with earlier Boston data as well as with the 1962 San Francisco findings (Room 1972) and the 1964-65 ADP summaries (Cahalan et al. 1969). Useful comparative data on the percentage of drinkers in the adult population and their sociodemographic characteristics are reported regularly by Gallup (e.g., 1966, 1974, 1977). These surveys are based on probability samples of approximately 1,500 respondents.

In summary, the household survey is being used increasingly to provide reliable estimates of problem drinking prevalence in the general population. The sociodemographic, physical health, and attitudinal data that can be obtained through this approach have enabled health planners and alcohol service providers to identify high risk groups and better plan prevention and treatment efforts.

Survey Findings

The diversity of indices, scales, and other measures used to estimate the prevalence of alcoholism and problem drinking makes direct comparisons of findings extremely difficult. In order to make comparisons of even the most tentative kind, we have reduced research findings to their common denominators. As a consequence, the extensive theoretical and methodological variations found in these studies are glossed over. Research results are summarized according to three categories of drinkers often found in the literature: abstainers, heavy drinkers, and problem drinkers. Table 2 summarizes the methodological characteristics of the 13 surveys reviewed in the preceding section and their findings.

Abstainers. The only relatively "pure" unit of comparison among epidemiologic surveys is abstinence. Even the term "abstainer," however, can be variously interpreted. It may refer to one whose abstinence is lifelong or to one whose abstinence is limited to the past few years. Unless specific questions were asked, the category may inadvertently include abstaining or recovered alcoholics. Nonetheless, the category can serve as a useful basis for making regional, sociodemographic, and economic comparisons. All of the surveys previously discussed reported greater percentages of abstainers among females and older age groups. There is also common agreement that abstainers are most likely to be found among the following:

those who are of lower income, education, and socioeconomic status, those who are married or widowed, Southern Baptists or conservative Protestants, rural residents, black females, and persons living in the South.

Heavy drinkers. Nine of the studies attempted to identify "heavy" drinkers. The lack of consensus may reflect actual differences in drinking patterns by various populations at different points in time. Some variations are undoubtedly due to differing definitions and methodologies. However, the designation "heavy drinker" among all the survey measures consisted of the following minimum criteria: consuming five or more drinks per sitting more than half the time, and drinking at least two or three times a month.

One consistent finding is that there are more heavy drinkers among adult males than among adult females. Also, surveys conducted in large metropolitan areas tended to report the highest proportion of heavy drinkers. For example, higher rates of heavy drinking in big cities (more than one million population) were reported by Cahalan and his colleagues (1969).

Among the surveys in which data on additional sociodemographic variables were gathered, disproportionately large numbers of heavy drinkers were reported among persons who are male; between 21 and 50 years of age (especially males); those with higher educational status; single, divorced, or separated persons; residents of large metropolitan areas; Catholics, liberal Protestants, or nonchurchgoers with no religious preference; residents of the New England, Middle Atlantic, East North Central, or Pacific census regions; and those in higher income and socioeconomic statuses.

Problem drinkers. If one is willing to accept the notion that frequent, high-volume drinking is synonymous with problem drinking, the above data could be used to estimate prevalence rates. However, problems or troubles due to drinking are considered an integral part of the definition. The diversity of indices, scales, and other measures and of the items from which they were constructed in these varied surveys helps explain the lack of consensus regarding the prevalence of problem drinkers. Despite this diversity in the findings, some general patterns emerge. The surveys confirm that approximately 5 to 10 percent of Americans 18 and older are problem drinkers or possible alcoholics. For example, Mulford (1964) reported findings from a national survey that indicated that approximately 7 percent of the adults sampled had experienced at least one "trouble due to drinking." In another national study Cahalan and his colleagues (1969) found that about 6 percent of the sample were "heavy-escape" drinkers. Further, a preliminary summary prepared for NIAAA (1978) estimated that, in 1975, 63 percent of those who drank had no associated problems, 26 percent reported some troubles, and 10 percent were "problem drinkers."

There is general agreement among the studies that those at greatest risk for drinking problems are males, particularly 18- to 25-year-olds; urban residents; females 30 to 40 years of age; single, divorced, or separated persons; and those with no religious affiliation.

Problem drinking over time. Some findings reported in longitudinal studies indicate that drinking habits and alcohol-related problems may vary considerably over time. For example, Clark and Cahalan (1976) reported changes that occurred during a span of 4 years. The study was based on interviews with males 21 to 59 years of age. Although men with drinking problems at the time of the first interview were still likely to have some form of alcohol problem at the second interview, substantial proportions of drinkers with problems at the initial interview reported a complete absence of problems at the second. The authors suggest that situational factors may have a stronger bearing on a problem drinker's behavior than previously suspected.

Fillmore (1974) conducted a 20-year followup study of 206 people studied during their college years by Straus and Bacon (1953) and noted several interesting changes over time. A reduction of drinking problems with age was observed, but the phenomenon was less apparent in women than in men. This suggests that early alcohol problems may be a better predictor of future problems for females than for males.

The presence of alcohol problems at the initial interview, however, was clearly a better predictor of later problems than were either frequency or quantity measures during the original interview.

Bailey, Haberman, and Sheinberg (1966) discovered that changes in reported drinking behavior or drinking problems were frequently a result of later denial on the part of identified alcoholics or reflected inconsistencies associated with marked changes occurring in the lives of those being questioned. If situational circumstances do indeed have significant impact on the persistence of alcohol-related problems, this would cast doubt on the traditional notion that alcoholism is a progressive disorder that builds from low frequency/low volume drinking to high frequency/high volume and increasingly problematic drinking.

Summary

During the past 30 years, increasingly sophisticated alcoholism prevalence studies have been designed and conducted. Indirect measures such as the Jellinek formula and per capita consumption models are still in use, and rates-under-treatment analyses can provide essential descriptive information concerning the extent of the more severe complications of alcohol abuse, but community surveys are proving to be particularly useful in identifying the extent of low-level alcohol problems and groups of persons at high risk, as well as "hidden" (and previously uncounted) problem drinkers. Furthermore, such surveys can be conducted to assess need in areas of low population density or can be used when targeted studies are necessary to determine the service needs of special groups.

Not only do household surveys of drinking practices yield cross-sectional point-prevalence estimates of problem drinking, but also they show promise as a tool for extremely valuable longitudinal research. If, as some studies suggest, drinking habits and alcohol-related problems vary considerably over time, this has encouraging implications for the development of intervention programs.

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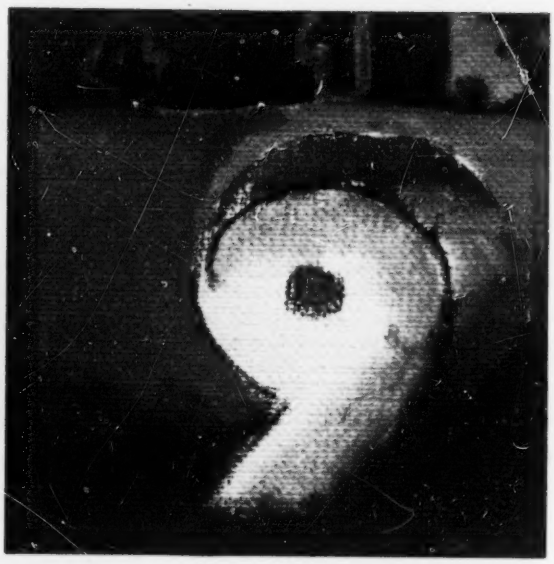

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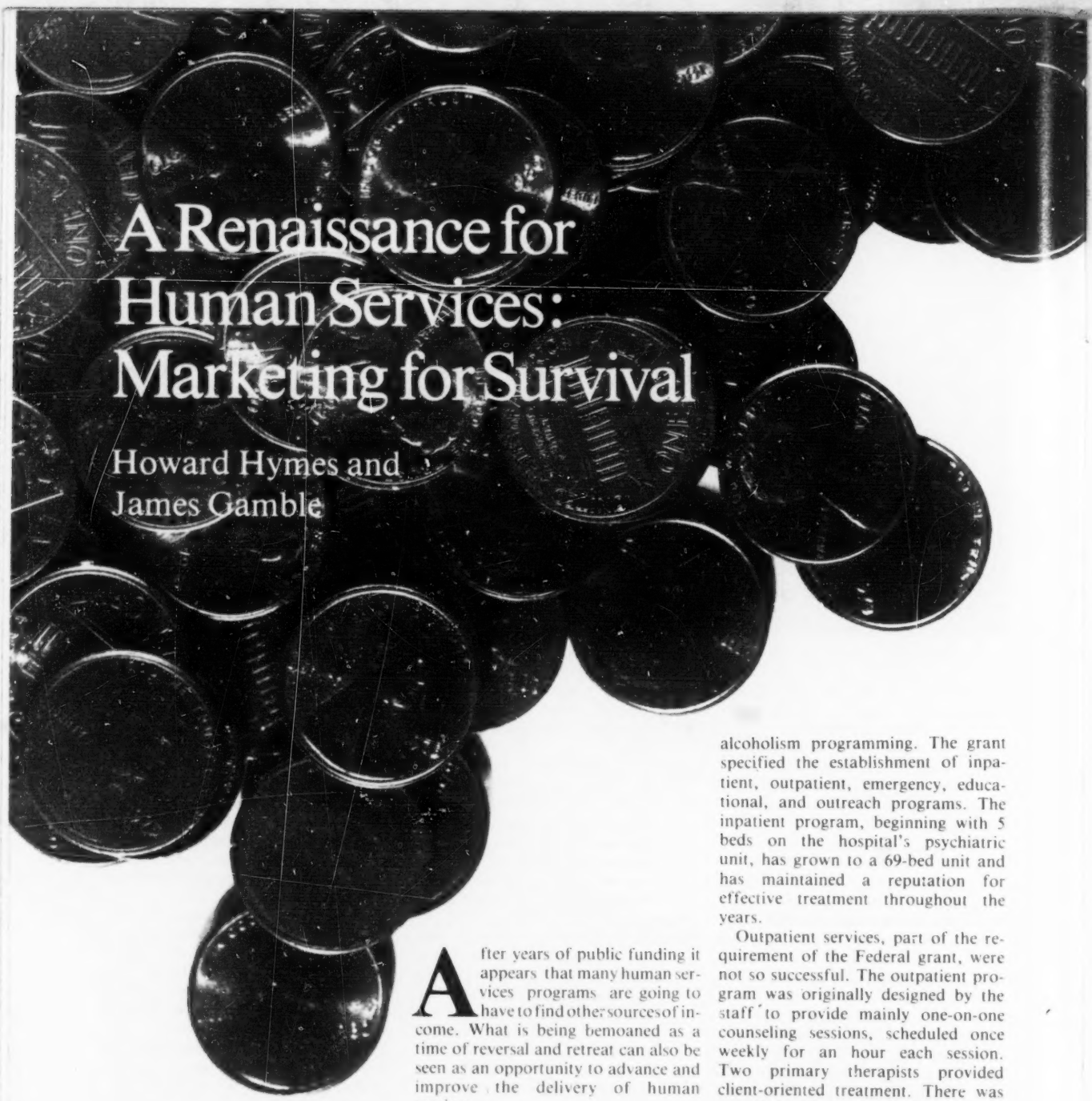

A Renaissance for Human Services: Marketing for Survival

Howard Hymes and
James Gamble

After years of public funding it appears that many human services programs are going to have to find other sources of income. What is being bemoaned as a time of reversal and retreat can also be seen as an opportunity to advance and improve the delivery of human services.

St. Luke's Hospital Medical Center is a private, nonprofit, metropolitan hospital located in Phoenix, Arizona, one of the most rapidly growing areas in the United States. In 1969 the National Institute on Alcohol Abuse and Alcoholism (NIAAA) awarded a staffing grant to St. Luke's Hospital behavioral health division to establish comprehensive alcoholism programming. The grant specified the establishment of inpatient, outpatient, emergency, educational, and outreach programs. The inpatient program, beginning with 5 beds on the hospital's psychiatric unit, has grown to a 69-bed unit and has maintained a reputation for effective treatment throughout the years.

Outpatient services, part of the requirement of the Federal grant, were not so successful. The outpatient program was originally designed by the staff to provide mainly one-on-one counseling sessions, scheduled once weekly for an hour each session. Two primary therapists provided client-oriented treatment. There was very little, if any, family involvement in the treatment process. The program was, from the beginning, beset by a high dropout rate. Relations with the inpatient program were poor, as the two programs operated quite independently and had little professional contact. Referrals of inpatients to the outpatient program were virtually nonexistent. Clients were generally walk-ins from the

street, and the outpatient staff had no program for outreach or referral building.

When the Federal grant was awarded, the primary aim of the St. Luke's staff and administration was to implement a quality inpatient program. However, the educational, outreach, and outpatient programs were seen as channeling mechanisms to facilitate entry into the inpatient program by resistant individuals. The counseling component was seen as a means of overcoming denial, a major obstacle to the alcoholic clients entering and accepting treatment. Outpatient care was not widely accepted by the hospital as a primary treatment modality in the hospital setting.

As a result, the outpatient therapists essentially maintained their own separate programs, with their own separate clientele. There was no coherent program format or standard procedure for handling outpatient clients. Therapists were responsible for all recordkeeping on their clients as well as all billing and collection for their services. Entry into the program was dependent on the availability of the therapist.

As the grant from the Federal Government was for a percentage of staffing costs only, the hospital had to provide for remaining costs through other sources of funds. Since the hospital was not "sold" on the need for outpatient services, these services were provided on an "as capable" basis and there was little incentive for the staff or administration to meet expenses through normal fee-for-services charges. The therapists expressed the feeling that services should not be based on the financial resources of the individual but rather on the individual's need for treatment. Further, the relationship of the therapist to the client was one of trust building. The requirement by the hospital that the therapists be responsible for the billing and collection for the services they provided was seen (and expressed) by the therapists as detrimental to that relationship. As a result, the income derived through the provision of these services never did meet expenses, and the funding grant was the primary revenue source.

In 1976 the St. Luke's Hospital agreement with the Federal funding source came to an end, and all grant monies were discontinued. Shortly thereafter, the hospital administration determined that the outpatient program should be dissolved and the resources allocated to the successful inpatient program. The administration decided that the inpatient services had been successful in building a quality program; that inpatient treatment of alcoholism was a more appropriate approach; that the outpatient program had not been adequately used; and that the resources committed to the outpatient program would be used better in an expansion of the inpatient program.

Some members of the staff, however, continued to believe in the potential value of an outpatient alcoholism treatment modality. In particular, staff were beginning to question the appropriateness of inpatient treatment for all clientele, and some new program approaches were being considered. Proposed to the administration was an outpatient treatment system that fused the intensive nature of inpatient treatment with the needs of many potential clients to maintain their daily routines, attending to their careers and families.

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The outpatient staff was informed that, if a case were to be made for the continuation of an outpatient program, they had to provide the hospital administration with the following: a documentation of the current situation; an assessment of the needs of the community (which had to be preceded by a definition of the "community"); a program design based on those perceived needs; a method of promoting the program; and a funding mechanism. Further, a system of evaluation had to be developed to document program effectiveness to the hospital administration, the community, and potential funding sources. In essence, the staff had to prepare, design, and implement a marketing plan for outpatient services.

Finding the Path

The first step in the plan, "Rescue the Outpatient Program," was to establish that there was indeed a need for such services, using techniques of market analysis. Historically, there had been a significant number of inpatients who ended treatment early because of an expressed need to "tend to business," whether it be a business, career, or family. A review of the records of the inpatient program for the previous year showed that 8 to 12 percent could not stay in a long-term inpatient program because of such commitments. Also, some simply could not afford long-term hospitalization for treatment.

Further review of the records revealed that many of the patients in need of detoxification did not require inpatient treatment; based on their attitudes and behavior as well as the quantity of alcohol typically consumed, it appeared that a number of alcoholic patients could be treated in the outpatient setting. This conclusion by the staff was supported by many researchers, who had found that intensive inpatient treatment of alcoholism was not appropriate for everyone manifesting drinking problems.

Further evidence of the need for outpatient alcoholism services was provided by an incongruent set of findings regarding the inpatient program. While admissions to the inpatient program had leveled off over its decade of existence, inquiries regarding treatment continued to increase. A review of the telephone logs from the intake staff of the inpatient program showed a steady increase over several years in the number of calls inquiring about services. Indeed, for the year previous to the review there had been an almost 10 percent increase in inquiries over the prior year. At the same time, there was no corresponding increase in admissions. Because the inpatient staff was not making referrals to the outpatient program to any significant degree and the increase in inquiries was not being transmitted into an increase in admissions, it was concluded that many potential clients, concerned enough to make an inquiry, would not use a program that required hospitalization. Whether it was because of obligation to conduct their daily affairs, the cost, or the stigma attached to hospitalization for a problem such as alcoholism, the needs of a significant number of people were not being met by the inpatient program.

Additionally, staff members conducted a "key informant" survey of various community leaders such as business and industry managers, church leaders, private counselors, program and agency administrators, and insurance company managers. The consensus was that there were considerable numbers of people exhibiting alcohol-related problems and that there were many people in need of services whose life situations prevented hospitalization or who simply would not accept hospitalization. Also, there were many people in need of services without adequate personal financial resources or medical coverage to fully use an inpatient program. Generally, the survey confirmed that an outpatient program that could be proved effective and inexpensive would receive referrals from them.

A Look in the Mirror

After establishing that there was a need for outpatient services, the staff turned to the question of the existing program. If there was a need, was the program meeting that need, and if not, why? What were the requirements of a successful program? What were the needs of the staff and the hospital administration?

To facilitate the inquiry, the staff developed a set of parameters for success. A successful program first had to be effective in arresting alcohol-related problems. Second, it had to be accessible to potential clients. Third, it had to pay its own way.

An internal audit of the existing outpatient program was conducted to see how well it met the criteria. The results of the study showed the following:

- The outpatient program had a very small number of clients enrolled for services.
- In the year previous to the audit, 68 percent of the clients registered for treatment in the outpatient program terminated their participation before the third visit.
- The treatment modality was primarily one-to-one counseling sessions. Ninety percent of all outpatient treatment offered was individual counseling once a week, an hour per session. The remainder was group meetings.
- Among individuals engaged in group treatment, the average length of attendance was six sessions.
- Record keeping and billing and collection were left to the therapists, with the result that collected revenue did not meet expenditures for the program.
- The outpatient staff felt their function was solely to provide therapy; they did very little planning and almost no promotional work to increase community referrals. Further, the outpatient staff viewed treatment as a right and billing and collection as a detriment to the relationship between the client and the therapist. The rate of collection on accounts due was less than 25 percent.
- There was no insurance coverage for outpatient treatment.
- Intake (documented in literature as a critical process) was hit or miss, depending on the availability of a therapist.

•Inpatient treatment staff did not recognize outpatient treatment as an effective treatment modality, and fewer than 3 percent of the referrals to the outpatient program for the previous year were from the inpatient program staff.

•Despite the literature regarding the need to treat alcohol-related problems as a family problem, very few families or significant others attended treatment sessions.

•Referrals from community agencies, business and industry, and community professionals were virtually nonexistent, constituting 5 percent of the previous year's admissions.

•There was no mechanism for evaluating program effectiveness.

In addition to agreeing to the internal survey, the administration had contracted earlier with an outside agency to assess the community awareness of St. Luke's behavioral health division programs. That assessment indicated almost no community visibility for the outpatient program, with fewer than 1 percent of the responding sample aware of it.

It was readily visible from the audit results that the outpatient program, as it then existed, was not meeting any of the originally defined criteria for a successful program. With no evaluation component in the program, the success or failure of the treatment offered had to be inferred from the available data. Literature showed that the success rates dropped sharply for clients who left treatment prematurely. Given the large number of terminations even before the third visit, it was felt that those clients were not significantly helped.

Second, the intake process was not well coordinated and depended on the availability of a therapist. Research showed that intake was a critical step in getting a person having alcohol-related problems into treatment. The client had to be made to feel that, in the face of a problem that had brought him or her to the point of seeking help, there was hope for successfully dealing with the problem, and that he or she was with people who cared and would help. The client had to be brought into a supportive milieu immediately to reinforce that he or she had "done the right thing." In the existing program, the secretary was not a part of the treatment team. She knew very little about the program and its workings, and did not (and could not) offer support to the incoming client. Many clients were left waiting for a chance to talk with a therapist, and beyond that, many had to wait days and even weeks to actually enter treatment. There was no means of determining attrition due to the poor intake process, but the staff felt that it was considerable.

Third, the program was in no manner paying for itself. For the previous year, therapist salaries alone totalled nearly $51,000, while revenue generated from registered clients totalled $49,830 and the actual collections on these accounts amounted to only $12,000. It was no wonder that the administration was looking for a more appropriate allocation of its resources.

The need for the outpatient program had been established, as had the fact that the existing program was not meeting those needs. The staff then turned to the task of designing a program that could provide the kind of service to meet the needs of those potential clients not being helped by either the inpatient or the existing outpatient programs.

A Renaissance Begins

To this point, only certain members of the staff directly involved with the outpatient program had been involved in the process. In designing a new program, it was strongly felt that the inpatient staff would have to become involved, since a major problem with outpatient therapy had been the lack of acceptance by the inpatient staff. It was felt that if the inpatient staff participated in the program's design it would be more readily accepted by them, forging the first crucial link between the two programs.

The first step in the process was a literature search, conducted by members of the inpatient and outpatient staffs. Information thus uncovered was shared among the staff members in informal meetings. Some of the most pertinent data showed that the great majority of people suffering from problems with alcohol did not need inpatient care. Further, several investigations showed that, when evaluating longer versus shorter inpatient stays, the shorter stays seemed to be as effective as the longer, for the average client. At least one group of researchers had come to question the need *at all* for the inpatient treatment of the *average* alcoholic. Participating in the uncovering of this type of information did much toward amending the inpatient staff's negative view of outpatient alcoholism treatment.

In developing a program design, certain factors were felt to be essential to an effective program. These factors were based on research and the experience of the successful inpatient program. It was felt that the treatment needed to be supportive and intensive, and that it was very important to involve the family or significant other of the alcoholic directly in treatment. A model was found in a program as yet largely untried, from the Johnson Institute of Minneapolis, Minnesota. The St. Luke's program was thus developed into an intensive group treatment experience. Groups were to be formed with a therapist and would meet 5 nights a week for 4 hours each night, for 4 weeks. The spouse or significant other person in the alcoholic's life was enrolled and attended the group's sessions along with the alcoholic. Therapy focused first on stopping the drinking, using methods developed by Alcoholics Anonymous, and on the personality of the client

and his or her relationship with the family or other significant person(s).

The intake process was redesigned to facilitate engaging and keeping the client in treatment. The entire staff, including the secretary, was to act as a team in assisting the client in entering treatment. The focus was to make the staff available and the entry into the program easy and simple. Many hours of training were spent on the importance of the intake process and the development of an intake mechanism that would get the client into the process immediately.

An evaluation component was established, wherein the client would be given a questionnaire during the intake process that assessed alcohol consumption, self-image, family, work and life problems, and so forth. The questionnaire was to be readministered to the client after 6 months following treatment, again at 1 year, and again at 2 years following treatment. This was considered critical in documenting the degree of the program's success and then promoting the program in the community and among the inpatient staff.

The billing and collection procedures were also addressed. The redesigned procedure left the administrative record keeping to the secretary and the billing and collection to the hospital and financial offices. Also, clients were given financial counseling prior to entry into the program to help them understand their financial responsibility in the treatment process.

From Concept to Reality

In January 1977, administrative approval to initiate the program was given on a tentative basis. The first clients were registered and groups were formed. Once the program was underway, attention was turned to developing community awareness and a referral network and to getting insurance carriers to include the outpatient program in their coverage. The staff felt that it was best to let the program operate for 6 months and to review the first evaluation study before approaching the community or insurance carriers. In the meantime, the staff developed a creative and entertaining presentation on the program and began to look for contacts within the community.

The results of the initial evaluation study were promising, showing a drastic decrease in early terminations and excellent treatment outcomes. The results were formalized for presentation to insurance carriers, courts, and the community treatment network and were incorporated into the presentations for the community.

In developing community contacts, it was felt that courts, attorneys, and community professionals and agencies would be a valuable referral source, so special presentations were developed for those groups. The general community, however, was not so easy to reach.

Within the metropolitan area were a large number of women's groups. These were targeted as a means of spreading the word throughout the community to increase public awareness and obtain self-referrals in the absence of advertising money. The groups had not been approached by other behavioral health programs for presentations or support, and needed good program presentations. Within an 8-month period the staff gave 40 presentations to various professional and nonprofessional women's groups. The presentations had a snowball effect, with many of the women providing introductions to other groups and, most important, assisting the staff in presenting the program to several insurance providers.

The promising results of the initial evaluation studies and the introductions and assistance from community members (particularly individuals within the women's groups) provided a solid foundation for approaching insurance carriers. By showing a highly developed treatment concept, quality treatment outcome measures, community support, and treatment costs drastically lower than inpatient treatment, insurance coverage was provided, for the first time in the area, for outpatient alcoholism treatment. By the end of the first year of operation, 26 insurance carriers were providing coverage for outpatient treatment at St. Luke's.

A data collection system was designed and implemented at this point to chart referral sources, assess program awareness, and document insurance coverage. This information was collected during the intake process and used to assess the impact of the promotional work and to identify areas where more work needed to be done. The system has continued and been refined over the years and has proved invaluable in resource allocation and eventual expansion of services.

Marketing for Survival

In the period of a year, a few staff members, convinced of the valuc of the outpatient approach and armed with the rudiments of a marketing concept, rescued a moribund program and turned it around completely. The results of the changes made and the work that had been done are summarized in table 1. The results were dramatic and compelling. The program has since continued to grow and prosper. Two new satellite programs were developed in outlying areas that the continued market assessment had shown were not being served. Further, the program was used as a model in developing an outpatient program for a publicly funded agency. As a further benefit, the expansion of the program into outlying areas drew clients in need of inpatient treatment into contact with the St. Luke's program, expanding the inpatient referral area.

This is a time of retrenchment for social programs. Funding is less available and many programs are in danger of extinction. Not all programs can emerge in the same manner as the St. Luke's outpatient program did. Not all publicly funded programs can find alternative funding sources. But by using proven techniques of market analysis, programs can take a hard look at the services they provide and the market segment they serve. Based on this, they can then determine their effectiveness in providing services, make adjustments to minimize unproductive work, and take their programs out into the community and seek out alternative funding sources. Reductions in public funding may provide the incentive for self-evaluation and may result in improvements in the delivery system and innovations in program offerings.

Table 1. Comparison of program before and after inception of market strategy

	1976	1977
Referrals from inpatient program	3 percent (11)	33 percent (68)
Program-initiated community contacts	11	216
Community visibility (assessed by independent survey analysis of behavior health programs)	1 percent	Referrals from Attorneys....15 percent Physicians....10 percent Community individuals..30 percent
Number of treatment sessions	2,640	4,800
One-to-one counseling sessions	90	10
Group sessions	10	90
Early termination of treatment	68	8
Staff salaries	$51,000	$ 69,000
Revenue generated	$49,830	$180,000
Revenue collected	$12,457 (25)	$ 99,000 (55)*
Insurance coverage	0	26 carriers
Financial "bottom line"	−$38,534	+$ 19,500

*Revenue collected has since increased to over 85 percent.

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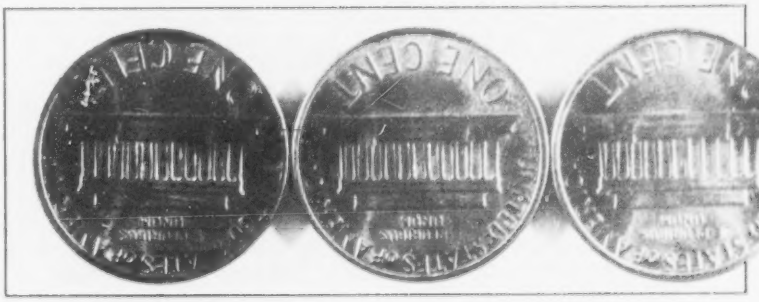
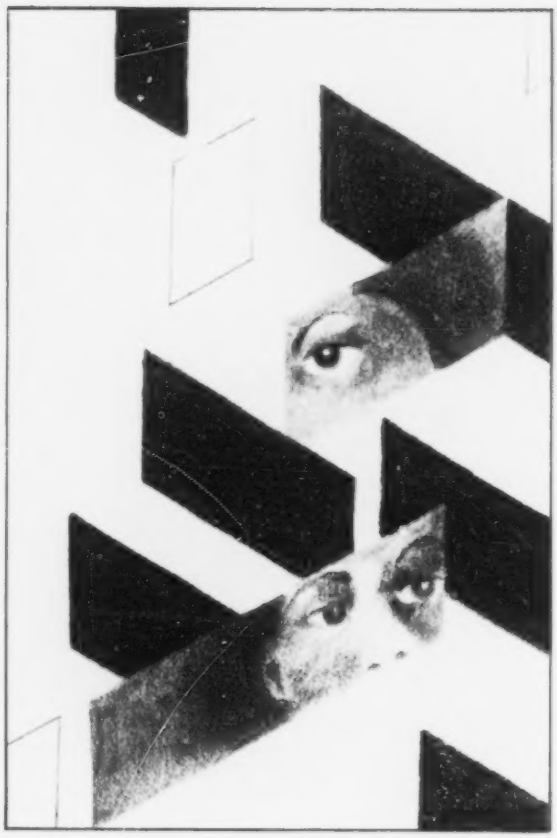


How Women Recover:

Experience and Research Observations



Editor's Note: In December 1981, representatives of 40 of the 45 women's treatment programs funded during the preceding 11 years by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) met in Minneapolis to discuss the knowledge gained from their experiences in treating women with alcohol problems. NIAAA is no longer funding alcoholism services programs, but rather is mandated to focus efforts on alcoholism research and information dissemination. This article is excerpted from a monograph based on the conference, and includes a summary of the observations of the conference participants and the complete text of the final chapter of the monograph, which reports on research literature related to women's treatment issues raised by conference participants. Joan Volpe, Ph.D., was the author of the final chapter. Gayle Hamilton and Volpe were the primary authors of the monograph. Margaret Wilmore of NIAAA was the coordinator of the conference and monograph. *Advances in Alcoholism Treatment Services for Women* is expected to be published later this year.

Conference Objectives

In the 1970s the National Institute on Alcohol Abuse and Alcoholism (NIAAA) met the challenge of treating women with alcohol problems by establishing program guidelines and funding women's centers. In the ensuing years, 45 programs were funded to provide services to women with alcohol problems. Considered, in part, as an experiment focusing on treatment needs of a particular, albeit heterogeneous population, the Institute felt the impetus to gather information about the progress of these programs.

Policy changes have shifted the administration of alcoholism services programs from the National to the State level of operation. As a result, NIAAA is no longer funding service programs. Partly because of a desire to trace the history of its funded women's programs and partly because of its new role in research and information dissemination, NIAAA staff set out to collect experiential data from the field regarding the treatment of women with alcohol problems.

The most useful and comprehensive method for gathering and examining such experiential data seemed to be to convene a national conference of directors of the NIAAA-funded women's treatment centers. The conference was designed to achieve maximum participation through the use of small workgroups. Five major themes were selected by NIAAA staff and the women's programs as the most significant areas for exploration. The topics included outreach and identification issues; treatment issues and practices; aftercare planning; the importance of community/State support; and evaluation/outcome criteria.

The 38 women's programs represented at the Minneapolis conference varied in terms of urban/rural geographical setting, type of treatment, administrative structure, and subpopulations of clients served. While not evenly distributed throughout the country, programs were located in the northwest, west, southeast, central, and northeast areas, and in urban, suburban, rural, and reservation communities. They served white, black,

Hispanic, and Native American women and their families. The majority of clients were low and middle income women.

A wide range of services were provided by the programs through both freestanding and umbrella agency structures. The treatment settings included hospital/clinic, residential, halfway house, outpatient, or daycare. Some operated within coed facilities, but the vast majority were exclusively women's programs. Several programs provided residential service for women and their children. Each of the participants reported on a wide range of experiential data; however, the observations at the conference cannot be considered as representing the needs of all women clients, even in these 38 programs. Nevertheless, the information is useful for the field because it represents present "clinical wisdom." Within a context of widespread dissemination efforts, the information developed from the conference can serve a number of functions for a variety of service providers and training organizations. For programs yet to be established, there is important information about community planning, treatment planning, staffing needs, and special women's issues. For existing programs in alcoholism, drug abuse, mental health, and other health/social service agencies, the ideas and observations may provoke new approaches to outreach, marketing/funding, treatment planning, and aftercare for women with alcohol problems. For State and local agencies interested in training and in research, it is hoped that the information will stimulate planning in this area.

Major Themes

Two themes were repeatedly expressed by participants at the Minneapolis conference. The first theme related to women's programming that was seen by participants as holistic in nature. The second theme focused on women's concerns, reflected in the culture in general, that heavily affect all program activities. In reviewing the specific issues and strategies that emerged from the conference discussions, it is clear that these programs are living their ideologies.

In all five of the conference topic areas, participants maintained a broad definition of the purposes of their activities, transcending textbook definitions. The impression created by the participants was that of an expanded vision of alcoholism treatment that had arisen out of the necessity of dealing with a very complex set of societal issues. Such issues make it impossible to deal in a parochial manner with casefinding, treatment, or provisions for ongoing support to women alcoholics. Cultural mores seem to protect women while rejecting women alcoholics. Therefore, programs treating the problems of alcoholism in women *must* address sociocultural attitudes and role prescriptions. Furthermore, many of these programs have clients from minority racial groups and alternative lifestyles who are subject to additional stereotypes and stigma. The fact that the programs are predominantly administered by women tends to create discomfort in communities unaccustomed to seeing women in senior management roles. The service load of the programs is largely dependent on community resource personnel whose understanding of the programs' purposes, clientele, and directors may be clouded by myths, stereotypes, and fear.

Thus, *outreach activities* cannot be limited to casefinding. Casefinding itself is dependent upon changes in attitudes among professional caregivers, among friends and acquaintances of the female alcoholic in the community, and among spouses, and in attitudinal changes toward self among women in the community who have drinking problems. This includes changes in attitude not only toward the female alcoholic but also toward women in general. Outreach activities, therefore, include extensive community and professional education.

Treatment activities, according to participants, cannot be limited to recovery from alcoholism and the kinds of inner growth work characteristic of traditional mental health programs. Treatment activities in women's alcoholism programs must also address the personal limitations brought about by role constrictions. Participants stressed that, in order to successfully treat the alcoholism, the behavioral repertoire of their clients must be broadened. Areas for development must include behaviors considered to be appropriate for a healthy person, regardless of sex. This includes an emphasis—heretofore lacking in coed programs—on assertiveness, vocational development, and clarification of independent goals. Program staff must also work to repair the damage to self-esteem created by both the alcoholism and the roles clients play as women. Self-esteem is addressed in a truly holistic way, and includes an increased sense of well-being resulting from better health and increased capacity to manage stress; increased skills in communication and building relationships; a better understanding of sexuality; and increased competence in managing both independent employment and daily affairs.

Aftercare goes beyond the concept of merely providing ongoing support for gains made in treatment. According to participants, the very gains made in treatment may, in fact, create further stresses for clients, in that both family and community may respond negatively to the changes associated with recovery. Grief and sexual abuse are such deep and pervasive issues that frequently they are not addressed until the aftercare phase in treatment. In addition, participants noted an absence in the community of the sensitive, knowledgeable support systems

needed by women once treatment is completed. Therefore, even with limited staff resources, aftercare programs must often provide extensive crisis support, ongoing therapy in some cases, and community educational work to help create viable community support systems.

Community involvement for these programs has become a vehicle for marketing and fund raising, for gaining credibility as women-managed organizations, for changing community myths about their anti-male orientations, and for reducing general community fear about program purposes. Community involvement, then, includes lobbying, fundraising, providing educational workshops, obtaining media coverage, and responding in a helpful way to general community concerns bearing little relationship to alcoholism issues per se.

For these programs *research and evaluation*—specifically related to treatment outcome measures—include evaluation of issues far beyond just abstinence from alcohol. An evaluation of outcome must include changes in employment status (or changes in economic self-sufficiency); changes in management of home responsibilities, including parenting; changes in acceptance of personal responsibility; improved ability to deal with feelings, depression, sexuality, relationships, and assertiveness; increase in personal supports; increase in independence; and increase in cultural identity. While outcome studies are apparently important to the programs, participants' interest in research goes beyond knowledge of treatment outcome. Topics raised at the conference for future research consideration are listed at the end of this article.

In addition to the fact that *each* of the topic areas reflects a holistic vision and relates to women's issues, it is also clear from the conference discussions that all of the topic areas (outreach, treatment, aftercare, community involvement) are interrelated and must be dealt with as a continuum of care. The issues discussed initially in the outreach workshop merged with issues that were discussed in each of the subsequent workshops. In fact, participants were sometimes frustrated by the discrete categories under discussion because it became difficult to subsume actual strategies used into single topic areas. At the program level, staff viewed treatment as a continuous process, and therefore, carried out each specific activity of their jobs with impressive clarity about both immediate and far-reaching effects and purposes.

An additional issue of interest that emerged from this conference is that there must be recognition of the delicate balance required by staff if these women's centers wish to reach program goals. In order to get women to enter the programs, staff must significantly change public attitudes toward women and women alcoholics. Yet staff must be sufficiently identified with the local cultural norms to acquire the trust and respect needed to become accepted as a viable organization in the community. In order to effect healthy sobriety and create a more androgynous repertoire of behaviors, staff must encourage the broadening of their clients' sex role perspectives. Although this is perceived by staff to be important for the women's recovery, it sometimes causes the client to experience considerable fear and anxiety. Furthermore, persons important to clients may respond negatively. Such situations necessitate that staff be especially sensitive to the potential stresses that treatment itself produces.

It is hard to ignore the paradox faced by a woman who wishes to be an achiever in our society. High achievement may arouse fear and rejection of her role as a woman; acceptance as a woman sometimes requires foregoing personal goals of achievement. Attainment of both requires maintaining a very sensitive and delicate balance in behavior and attitude. Perhaps the directors of the women's centers represented at this conference, most of them women, are exceptionally well suited and trained for the roles they must now play. And perhaps these difficult roles have created the imperative that women's center directors feel toward extensive staff training and establishment of a consistent staff philosophy toward all aspects of women's programming. Certainly, clarity surrounding their goals with clients and community, and clarity about the far-reaching effects of all program activities, serves to reduce the anxiety that must be a part of managing such a complex set of strategies.

A Research Perspective

Perceptions of the path to sobriety vary among alcoholic persons experiencing recovery, counselors assisting in the recovery process, and researchers investigating recovery patterns. Yet, somehow, interpretations must be made that offset these varying perceptions if we are to uncover the basic underlying themes associated with the etiology and treatment of women's alcoholism.

Currently, our understanding of alcoholism comes both from data gathered by researchers that may or may not include clinical research and from the experiential knowledge of therapists and recovering alcoholics. Clearly, information gleaned in one source is not in diametric opposition to that gathered in another, but somehow the two arenas of research and treatment have not been steady companions in the long search for enlightenment about women's alcoholism.

Over the past 11 years, attention has been given to the problems of women and alcoholism through the funding

efforts of NIAAA. During these years a total of 45 treatment programs were funded to address the recovery needs of female clientele. The majority of these women's treatment programs have been in operation from 3 to 6 years. The most senior programs were started 10 years ago.

A careful scrutiny of available research data makes it clear that, although we have amassed a body of literature about alcoholism, alcoholics, and alcoholism treatment, it is still unclear whether what we now know is generalizable to various segments of the alcoholic population. This concern has particular relevance for the subpopulations of female alcoholics whose problems, until recently, were either ignored or viewed as congruent with alcoholism in men.

By organizing a forum of program directors of the federally funded women's treatment programs, NIAAA has provided the alcoholism field with an opportunity for cross-fertilization of alcoholism information. In this section, attempts are made to link research findings on women with experiential information provided by the participants attending the Minneapolis conference. This research review is organized to reflect the issues and concerns of the program participants as they know and understand the needs of alcoholism in women. Therefore, this is an attempt to examine the similarities and differences noted between research findings and experiential knowledge, rather than a literature review. Topics discussed by the program participants are addressed and findings relating to each of the topics are interspersed throughout the discussion.

The understanding of women and alcoholism presented here is based upon the experiences of the participants attending the conference *and* their perceptions of the needs of the particular groups of female alcoholics being served in their treatment centers. While very informative, and in many cases quite insightful, the experiential information is not generalizable to the total population of alcoholic women. Clinical wisdom expressed by these participants about specific groups of women alcoholics, however, provides pertinent information about the needs and issues of women alcoholics in similar circumstances.

Characteristics of Women Alcoholics

Reviews of the literature indicate that women alcoholics begin drinking at a later age than men, but that women appear for treatment at the same average age, which suggests a telescoping effect in women's alcoholism (Curlee 1970; Elder 1973; Glatt 1961; Lisansky 1957; Sclare 1970; Wall 1937; Wanberg and Knapp 1970; Winokur and Clayton 1968). While conference participants did not attempt to compare the onset of alcoholism between men and women, there was general agreement that a telescoping effect was evident in their populations of alcoholic women.

As noted in the literature, case finding of women alcoholics has been particularly problematic (Blume 1978). Closet drinking, extreme feelings of guilt and shame, social rejection, and misguided protectiveness by caring persons have had the effect of isolating the female alcoholic. Caught up in a spiral of guilt, stigma, isolation, and protectiveness, women hesitate to seek help for their alcoholic problems.

Research findings show that the average age of women seeking treatment is around late 40s and 50s (Cahalan et al. 1969) or between 40 and 50 at the time of hospitalization (Schuckit and Morrisey 1976). The representatives of the women's treatment programs represented in Minneapolis report a decline in the average age of their client population. Taking an active stance on casefinding, many of these programs have focused attention on the multiple needs of their target populations and on the special needs of some subgroups in that target population. Strategies for outreach are designed to address sociocultural differences of the subpopulations of women in each community. Marketing their programs through the media, raising community awareness of the problem of women and alcoholism, and forming alliances with professional groups and gatekeepers have served to improve casefinding and to bring women into treatment at an earlier age.

Although it was not possible to ascertain a composite average age of clients for the 38 programs in attendance, it is significant that most of the programs represented at the conference spoke of a declining average age. With the advent of alcoholism treatment facilities focusing on specific needs of women, it appears that female problem drinkers are entering treatment at a younger age. Reasons given for the declining average age include substituting a holistic model of health for the more traditional image of alcoholism treatment, thereby reducing stigma, and increasing outreach efforts to teenage populations.

The age of clients entering treatment varied among subpopulations, according to the conference participants. One Native American program reports an average age of 28 for women clients. Program staff believe that the high rate of cirrhosis among this subpopulation of alcoholic women leads to early treatment referrals. Programs targeting Hispanic women continue to have problems reaching and treating that female population. Directors from these programs are aware that there are many women in the Hispanic community in need of alcoholism services, but resistance from Latin men continues to be a barrier to treatment. Until Latin men are more accepting of alcoholism treatment

facilities, programs with a target population of Hispanic women do not expect to see an appreciable decline in the ages of their clients.

Early life disruptions. Alcoholism in relatives and disruption in early life experiences are topics frequently noted in the research literature on women alcoholics. There seems to be a general agreement in research findings that incidence of alcoholism is higher in families of female alcoholics than in those of male alcoholics (Jones 1972; Winokur and Clayton 1967, 1968), or at least that there is a high incidence of alcoholism in relatives among women alcoholics (Jacob and Lavoie 1971; Johnson et al. 1966; Lisansky 1957; Wood and Duffy 1964).

Although no estimates were given by conference participants regarding the number of women in treatment having alcoholic relatives, their clinical findings are supportive of research data. Some of these programs indicated that not only is alcoholism high in the families of their clients, but it is not unusual to provide treatment to relatives of the alcoholic woman or to have a spouse or lover receiving treatment simultaneously from the parent organization or other local alcoholism agencies.

Findings on the association of early life disruption with alcoholism in women vary by social class (Curlee 1970; Kinsey 1966; Lisansky 1957) and by type of disruption (DeLint 1964; Rosenbaum 1958). While disrupted early life experiences appear to be related to alcoholism, family life disruptions caused by broken homes and psychopathology are also seen in psychiatric populations (Gomberg 1976, 1978). Therefore, disruption in early life may be considered a high-risk factor for later problem drinking, perhaps necessary but not sufficient to explain alcoholism. The question is why person A develops neurotic or antisocial behavior and person B develops alcohol problems, when both have had negative early experiences.

The topic of disruption of early life experiences for the female alcoholic arose intermittently throughout the Minneapolis conference. Since clinical findings regarding this topic were not discussed with any consistency by the participants, it is impossible to draw conclusions as to whether early life disruptions are a significant feature in the drinking histories of the women in treatment at these facilities. Such disruption, furthermore, is not an essential component in rehabilitation which according to participants must focus on the here and now and current life crises.

While disruptive experiences in general were referred to with inconsistency at the meetings, emotional and physical problems resulting from incest and rape were frequently addressed. The majority of the program directors in attendance reported that many of their clients had been victims of incest or rape or both. Programs reporting clinical data of sexual abuse indicated that as many as 45 to 70 percent of their clients had been so victimized. One participant reported the rate of sexual abuse as high as 90 percent. These figures on the incidence of incest and rape may appear high when compared with available data in the literature. However, program representatives believe that this discrepancy exists because there are hesitancies to reveal or to ask about the sensitive subject of sexual abuse. According to program directors, women alcoholics in coed treatment facilities hesitate to discuss sexual abuse in mixed company. Even in all-women's programs the client is often reluctant to speak of incest or rape until she feels a sense of security. Second, until questions regarding sexual abuse are asked on a regular basis by researchers and other clinicians, the information on incest and rape will remain hidden. It may be true that the women who enter alcoholism treatment are more likely to be carrying a double burden—problem drinking and a history of sexual abuse—than are women alcoholics who are not seen by treatment facilities. For now, it is clear that clinicians are suggesting a hypothesis about the significance of early sexual abuse in the development of later drinking problems, and that researchers should be exploring that hypothesis.

Precipitating events. Many research reports indicate that women alcoholics are able to identify a specific incident in their lives that is associated with the onset of heavy drinking (Belfer et al. 1971; Burton 1973; Curlee 1970; Franck and Rosen 1949; Hoffman and Noem 1975; Lisansky 1957; Mulford 1977; Wilsnack 1973).

Writing in 1974, Gomberg suggested that this association of problem drinking and a stressful event or situation may in fact be a consequence of women's needs to justify alcoholic drinking, thereby reducing the stigma attached to female alcoholism. Schuckit and Morrissey (1979), studying a large sample of women, found that a particular stressful event was not given as an associated factor in the drinking histories of this population. Volpe's (1980) work with a group of halfway house women corroborates Gomberg's assumptions.

By and large, program directors at the conference agreed that an explanation of alcoholism in women that posits a major precipitating event is unfounded. It is true that many women in treatment speak of distressful events in their lives when they recount previous drinking behavior.

However, abusive drinking for most of these women predated the specific event(s) identified. On the basis of clinical experience, it appears that as rapport with counselors increases, clients' need to speak of a precipitating event decreases. Reducing the need to justify alcoholic drinking enables the women in treatment to look at the progression of her alcoholism. Writing of the societal censure of alcoholism in women and the need to shift responsibility to an outside event, Corrigan (1980) suggested, "Given our present state of knowledge . . . it seems preferable to understand the course of alcoholism as an ill-defined illness rather than to look for causation in a given life situation" (p. 158).

The need is for researchers to shift from an emphasis on traumatic events as precipitant toward the kind of epidemiological, lifespan research that studies trouble points or stress points in peoples' lives. Some current work suggests that younger women (under 35) may be more vulnerable to problematic drinking after separation or divorce and that, at all ages, women who work outside the home often feel harried by the demands of two roles and may turn to alcohol. The program directors, however, are suggesting that attention be shifted away from the *specific* precipitant.

Biological features. Medical disorders associated with women and alcoholism are frequently referred to in the literature. While each of the Minneapolis conference attendees could provide a laundry list of physical ailments suffered by their clientele, all were in agreement that the women alcoholics in their programs had a very high proportion of gynecological disorders. Studies of women alcoholics corroborate these clinical findings (Curlee 1970; Kinsey 1966; Wilsnack 1973).

Considerable attention has been paid in the literature to the relationship between obstetrical-gynecological phenomena and the effects of alcohol upon women (Belfer et al. 1971; Dubowski 1976; Jones and Jones 1976*a*, 1976*b*; Lolli 1953; Podolsky 1963). Discussions range from differing blood alcohol levels at various phases of the menstrual cycle to the relationship between premenstrual tensions and alcoholic drinking.

Information regarding whether gynecological and obstetrical difficulties preceded as well as followed problem drinking was not a topic for discussion at the conference. Many of the programs gather such information through medical histories, but the focus of program directors at the Minneapolis meeting was on treatment needs of clients vis-a-vis the high rate of gynecological problems in evidence.

Holistic treatment of the female alcoholic suggests looking at all factors associated with a woman's problem drinking. Biological events of menstruation, menopause, pregnancies, miscarriages, abortions, or infertility are attended to during the recovery process only insofar as they appear problematic for the client while in treatment. While there is no intent to minimize the importance of any factor that may be associated with alcoholic drinking, there is also no apparent need felt by these programs to single out particular biological events as being precipitous of a client's alcoholism problem. Instead, each event seems to have importance as a means of understanding the overall schema of treatment needs—for example, how menstrual stress or menopause fits into a woman's sociopsychological life situation. Medical researchers could contribute to rehabilitation programming by supplying data and information about medical consequencess of heavy drinking for women in different age groups, women who combine alcohol and drugs, and other factors.

Psychological features. Without intending to be scornful of the time and effort spent by researchers on depression as a significant factor of alcoholism in women (Jones 1971; Schuckit 1972; Schuckit et al. 1969; Winokur and Clayton 1968), program staff consider depression to be so symptomatic of alcoholism as to render the large amount of research attention to this concept meaningless.

Depression is an accepted fact of alcoholism for both men and women. A distinction between alcoholic depression and clinical or psychiatric depression was made by all of the programs represented at the conference. Most of the female clients in these facilities are clinically evaluated as being alcoholic with *accompanying* depressive symptoms. Clinical experiences indicate that as the women become sober, depression diminishes. However, if a client's depression continues after successful completion of treatment or if symptoms of depression reappear later on in recovery, the treatment staff will refer the client to other professionals for assistance.

Until recently, women clients in treatment were predominantly characterized as being alcoholically depressed. Changes in deinstitutionalization statutes, however, have created an increase in client populations at these agencies of women with primary psychiatric problems and secondary alcoholism.

While the topic of depression as a treatment issue received little attention at the Minneapolis conference, issues of self-esteem and self-concept were seen as crucial to the understanding and treatment of women's alcoholism. Low self-esteem, poor self-concept, and dependency are overriding characteristics of women in treatment, according to conference participants. Research on women alcoholics suggests that a central feature of female alcoholism is not dependency, but rather a preoccupation with femininity and overevaluation of the wife-mother role (Kinsey 1966; Wilsnack 1972, 1973). Or, as Gomberg (1974) advised, "the alcoholic woman may be . . . conflicted and ambivalent about being a woman, she still protests her femininity while the more assertive aggressive aspects of her personality are denied, just below the surface" (p. 176).

Measurements of conscious and unconscious femininity are rarely sought by alcoholism counselors. However, the manifestations of poor psychosocial adjustment, low self-esteem, and feelings of inadequacy that characterize the women in treatment are clearly documented in clinical records. Whether these characteristics reflect sex-role conflict, unsuccessful

struggles to overcome rigid, self-deprecating attributes of traditional femininity, or a basic lack of confidence and self-worth is still unknown. A description of the female alcoholic found in the literature (Blane 1968) that supports clinical evaluations states that "the central, perhaps inevitable, feature in women with alcohol problems is a concern, even a preoccupation about being inadequate and inept, surrounded by an aura of futility that bespeaks her utter helplessness to change herself" (p. 112).

Lacking the confidence to have a positive self-identity, alcoholic women seen in treatment develop a self-image based upon relationships with others, particularly sexual relationships. Dependency upon these relationships is paramount for the woman who feels worthless and is guilt ridden about her own inadequacies.

Learned helplessness, passivity, and dependence upon others are characteristics of the traditional female sex role and of the alcoholic women seen in these treatment programs. Recovery from alcoholism, according to the conference participants, is correlated with developing a healthy balance of independence and dependence, learning skills to become self-reliant, assuming responsibility for self, *and* developing a comfortable, albeit new, identity as women.

When examining how alcoholic women see themselves as compared with nonalcoholic women, McLachlan and associates (1979) found, in a controlled study of 100 female alcoholics and 100 nonalcoholic women, the alcoholic women saw themselves as less effective in goal achievement, less socially competent, and more anxious than the controls. According to the experiences of the program directors, the dependency, self-esteem, and sex role issues observed in their clientele are similar to, but extreme forms of, sex role struggles of women in general.

Employment. Alcohol problems of women in the workplace have received some attention in the literature within the past few years, yet little is known about alcoholism and the working woman. One study suggests that employment may be a favorable prognostic factor in the recovery of alcoholic woman. From a sample of 136 women alcoholics, Bateman and Petersen (1972) found that females who were employed at the time of entering treatment had a higher rate of abstinence than those who were not employed. In another study, Schuckit and Morrissey (1976) found that women with lower status jobs remained abstinent for a longer period of time than did women employed in higher status occupations.

Six occupational alcoholism programs were represented at the Minneapolis conference, but the relationship of employment status to successful outcome was not a topic under discussion. Instead, these participants focused on the differing rates of identification of problems between men and women in occupational programs. Findings based upon experiential and empirical data gathered by these programs suggest that women's alcohol problems remain hidden in the workplace (Gomberg 1977). Reasons given by these participants to explain the lower rate of identification and referral of women with alcohol problems are that (1) women are more expendable to the organization than are the male employees; (2) stigma associated with alcoholism in women creates an aura of protectiveness toward the female problem drinker; and (3) supervisors find it difficult to discuss potential alcohol problems with female employees. The finding that married women working outside the home report higher rates of heavy or problem drinking than do housewives suggests that research is needed to learn more about drinking behaviors and problems of women in the workplace.

Stigma. Barriers to reaching and treating women alcoholics are well documented in the literature (Beckman 1975; Blume 1978; Curlee 1967; Gomberg 1974; Lindbeck 1972; Marden and Kolodner 1980; Sandmaier 1978). The most often cited barrier to helping the female alcoholic is the stigma that results from a moral definition of alcoholism *and* the double standard toward women who are intoxicated and alcoholic that serves to keep alcoholic women hidden.

National media campaigns, community education series, and personal testimonies have been forceful attempts to increase public awareness regarding the magnitude and scope of alcohol problems among women. But how effective have these efforts been in reducing the stigma associated with alcoholism in women? In some conservative rural areas, program personnel at the conference spoke of living in a time vacuum where alcoholism, male or female, is still considered a sign of moral corruption. Ethnic and religious groups continue to resist messages from "outsiders" about the alcohol problems of their people. And in some situations heightened awareness leads to public acknowledgement for the need for services, but lingering stigma coupled with fiscal limitations restrict services for alcoholic women.

Aware of the barriers to getting women into treatment, 45 federally funded programs pioneered to break through cultural, social, and economic resistance to provide treatment to alcoholic women. Although the literature on alcoholism and women may have prepared program staff for the difficulties they would encounter getting women into their treatment facilities, few of the program directors were cognizant of the ways in which stigma would affect the development and growth of their centers. From the accounts of the conference participants in Minneapolis, it seems that stigma attached to alcoholism in women is complicated by stigma against professional women providing services to alcoholic women. Yet to be documented in the literature are the effects of resistance from community groups to the establishment of women's alcoholism programs administered by a totally or predominantly female staff. As a result of the historical accounts of these programs, future research may wish to take a holistic approach to the consequences of stigma directed toward both client and helper, and using systems theory, investigate the relationship between stigmatizing factors and women's alcoholism service delivery.

Issues Related to Treatment of Women

Low representation of women in treatment centers, comparisons of male and female alcoholics using traditional measurements developed for male clients, and unrecognized differences in the recovery needs of men and women alcoholics have produced an inconclusive picture of the treatment needs of women. From the existing alcoholism literature, it can be surmised that female alcoholics have more psychopathology than do their male counterparts (Johnson 1965; Jones 1971; Karpmen 1948), have poorer prognosis (Bateman and Peterson 1972; Dudko and Kochev 1971; Glatt 1961), prefer individualized attention in treatment (Curlee 1971; Lindbeck 1975), and suffer with low self-esteem (Jones 1971; McLachlan et al. 1976), heightened feelings of guilt (Babcock and Connor 1981; Gomberg 1974; Sandmaier 1976), and sex-role conflict (Kinsey 1966; Wilsnack 1972, 1973).

Women's treatment programs characterize the female alcoholic somewhat differently. First of all, there is less tendency to make comparisons between male and female alcoholics and more focus on learning about the specific treatment needs of women. To accomplish this end, it became necessary for the programs to develop diagnostic techniques that addressed the multiple needs of the women seeking treatment. By so doing, these programs have moved away from conventional assessments focusing primarily on drinking behavior that had been originally designed for and used with male alcoholics.

In developing a treatment philosophy focused on women, these programs turned to a holistic model of treatment as a means of identifying clients' problems. In this schema, alcoholism treatment is understood vis-a-vis clients' roles and status as women, with alcoholism seen as one component of a client's total life experience.

Following a holistic model of alcoholism treatment, women alcoholics are seen as having identifiable gender needs that must be addressed in recovery. Agreeing with descriptions of women alcoholics found in the literature, the conference participants spoke of female clients as having low self-esteem, feelings of inadequacy, poor self-concept, and extreme guilt. Companion features to the expressed treatment needs are issues of dependency and exaggerated reliance on relationships with others for self-identity.

Comparing the psychopathology of men and women alcoholics is beyond the mission and interest of the women's programs and, therefore, not a topic for serious consideration. However, prognosis and outcome variables of clients in women-focused treatment programs are extremely important to the conference participants. Some of the programs have developed elaborate mechanisms for measuring outcome, but others have not had the finances to conduct followup and evaluative studies. "The quality of research evidence on the progress of the female alcoholic in treatment has contributed to the development of a sizable body of myth and speculation," according to Emrick (1975). Yet the experiences of the participants at the Minneapolis conference indicate that women alcoholics treated in programs using a holistic model of alcoholism recovery have a comparably high rate of treatment success. Representatives at the conference were strongly in favor of empirically testing their experiential findings. Furthermore, according to the participants, until we have learned about the effectiveness of alcoholism treatment that addresses women's needs, it is premature to make comparisons between treatment outcomes of male and of female alcoholics.

It was clear that outreach strategies, treatment needs, and aftercare planning vary within subpopulations of alcoholic women. Conference participants took the position that alcoholic women have certain generalized needs. Though varying in degree or intensity, these needs must be addressed during the recovery process. Because there is so little research information on the relationship between the factors listed below and successful outcome for women alcoholics, program staff continue to depend upon their experiences and perceptions of the importance of these issues to the successful treatment of alcoholic women.

Role modeling. Because role modeling is seen as an extremely important factor in women's treatment, almost all of these programs were strongly in favor of single sex therapy groups and a predominance of female staff. Statements have been made in the literature that the sex of the therapist is an important prognostic factor of the treatment outcome of women (Birchmore and Walderman 1975; Calobrisi 1976). But with the exception of one empirical study to support this idea (Ruggels et al. 1977), the supposition that outcome results for female alcoholics may be superior with female therapists remains untested (Annis and Liban 1980).

Dependency. Alcoholic women have difficulty seeing themselves as separate, autonomous individuals and instead develop identities based entirely upon their relationships with others. Dependent dyads must be examined during recovery, particularly how the alcoholic woman relates to her sexual partner. However, dependency issues are also evident with parents, families, friends, food, and so forth.

In keeping with dependency needs, alcoholic women coming into treatment prefer one-to-one relationships with counselors. Once introduced to group therapy, however, clients are very accepting of the group process and do well in this treatment modality. Because relationships are so important to the alcoholic woman, treatment

planning must be designed to include all significant persons in the life of the alcoholic woman.

It has been suggested (Curlee 1967; Lindbeck 1975) that individual therapy may be more applicable to women's treatment needs than group therapy. Even though it is widely accepted that no single modality will be efficacious for all alcoholic women, to date there is very little empirical information that analyzes the relationship of therapeutic modality to treatment outcome for women (Annis and Liban 1980).

Sexism and sexuality. Treatment staff and clients alike have been socialized to have stereotypic attitudes and expectations of women, of women alcoholics, and of homosexuals. The experiences of these programs indicate that alcoholism treatment for women is enhanced when clients and staff become aware of their own attitudes and beliefs that act as encumbrances to recovery.

The American Psychological Association's Task Force on Sex Bias and Sex-Role Stereotyping (1978) pointed to the need to eliminate biases in the process of therapy. Hare-Mustin (1978) warned male and female therapists about the subtle, often unconscious, patterns of behavior that act to humiliate and debase women in treatment.

Children of female alcoholics. There seemed to be a lack of agreement among program participants as to whether having child care as a component of alcoholism treatment enhances or hinders a woman's recovery. Two of the programs, one serving white women and the other treating black alcoholic women, firmly believe that without child care facilities their clients would not enter treatment. Furthermore, learning about effective parenting is important to alcoholic women with children and, in the opinion of these programs, occurs more naturally when women and children are residing in the same setting. Other program participants at the conference have found that alcoholic mothers need some distancing from their children in order to be able to focus on their primary needs in alcoholism treatment. In any case, all the program participants agreed that the children of alcoholic mothers have their own treatment needs resulting from growing up in an alcoholic family.

To date, there are no empirical data available that compare the outcome of alcoholic women who experience treatment conjointly with their children with women who enter treatment without their children.

Therapeutic modalities. Various forms of therapy are used by women's alcoholism treatment programs including reality, Gestalt, and Jungian therapies; behavior modification; and didactic, experiential, and peer counseling. Empirical data are unavailable regarding the relationship of treatment outcome and specific therapeutic approaches. The experiences of the programs suggest that successful outcome may be more closely related to individual client strengths and to the therapist's attitudes than to a specific therapeutic modality. Writing about treatment effectiveness, Gomberg (1974) gave her opinion that "the assets of the patient and the concern of the therapist are . . . the major determinants of effectiveness, not the treatment modality used" (p. 183).

Future Directions For Research

The conference participants raised a number of questions that will require further research.

Questions related to casefinding included the following:

- What is the relationship of selected outreach strategies to client response and client outcome?
- What impact do specific outreach strategies have on the needs of various subgroups of women alcoholics, such as blacks, Hispanics, lesbians, rural or urban residents, the elderly, women in the home, and women of different income levels?
- Are outreach activities more effective when conducted by one staff person or when the entire staff is responsible for a program's outreach component?
- Given cultural mores of male protectiveness that keep Hispanic women out of treatment, is a male Hispanic staff member preferable for outreach in Latin communities?
- Are women more apt to enter treatment in times of crisis than at other times?

The following questions were raised relating to treatment issues.

- Do women alcoholics have a higher success rate when their counselors are female?
- Are successful outcome rates higher for women alcoholics in women's programs than for those who receive treatment in coed programs?
- Are single-sex therapy groups superior to mixed-sex groups throughout the treatment process?
- Are holistic alcoholism treatment programs more effective than conventional programs for alcoholic women?
- What are the most effective ways to help a woman alcoholic in treatment learn to balance attributes of dependence and independence?
- What are the treatment needs of the children of an alcoholic parent?
- Is treatment for an alcoholic mother more effective when the children reside in the treatment center with her or when she enters treatment without the

children?
- Are homogeneous or heterogeneous treatment groups more effective for alcoholic women?
- Do the treatment needs of polyaddicted women differ from those of women who are addicted only to alcohol?
- Do women alcoholics fare better in treatment when their families are involved in the treatment process?
- Are specific treatment techniques more effective with certain groups of alcoholic women? How can this be measured?

Aftercare issues were also addressed by the conference participants. The following questions were raised.
- Is the effectiveness of an aftercare program directly related to a program's ability to assess women's needs during treatment?
- Should the structure of aftercare programs in outpatient and residential programs be similar or different?
- What are the most effective aftercare and followup strategies for various subpopulations of women?
- How is the issue of grief most effectively handled in treatment and in aftercare?
- What is the most effective length of time for an alcoholic woman to remain in aftercare? Does the time requirement vary for subpopulations of alcoholic women?

Questions related to the treatment of female subpopulations included the following:
- What strategies are effective in attracting and holding black women in treatment for alcoholism?
- Can programs treating predominantly white women successfully reach and treat black alcoholic women?
- Are there specific outreach and treatment strategies that are effective for lesbian alcoholics?
- What is the incidence of alcoholism among middle-class black women?
- Do elderly alcoholic women in treatment have higher success rates than do younger women?
- What are effective ways to reach and to keep Hispanic women in treatment?
- What is the incidence of fetal alcohol syndrome in Native American children?
- How can the high rate of cirrhosis in alcoholic Native American women be explained?
- Is the success rate for Native American women treated in culturally specific programs higher than for those treated in other programs?
- Do incarcerated alcoholic women have special treatment needs?
- Should different techniques be used by occupational programs to identify men and women alcoholics?
- What methods are effective in identifying and referring working women with alcohol problems?
- Is the single career woman different from the married working woman in terms of drinking behavior and outreach needs?
- Is the employee assistance program model better suited for single career women than for married working women trying to hold dual careers at home and in the workplace?

Finally, several general questions were posed:
- What is the most effective way to break through a community's denial of women's alcohol problems?
- How will the changes in funding structure affect alcoholism services that focus on women?
- Is Alcoholics Anonymous culturally relevant to minority groups and to women?

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FactsForPlanning 7

Drinking And Driving Among Youth

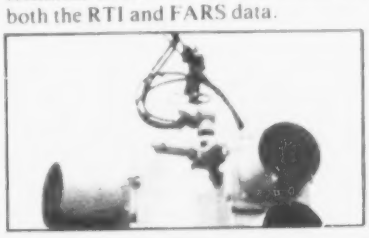
Cherry Lowman, Ph.D.
Clearinghouse Staff

National data on alcohol use, health, and motor vehicle accidents show that alcohol consumption, driving under the influence of alcohol, and involvement in alcohol-related accidents are extensive among youth, many of whom are under the legal drinking age.

More people between 15 and 34 years of age die from motor vehicle accidents than from any other cause (table 1). Many fatal motor vehicle accidents appear to involve drivers who are under the influence of alcohol; adolescents and young adult drivers are no exception. Clearly, the development of measures to reduce alcohol-related motor vehicle fatalities, particularly among youth, is an important challenge facing health planners, policy makers, and concerned citizens.

This report examines two types of facts useful to program planners. One type is based on standardized records of events—death records and fatal motor vehicle accident statistics. Age-specific death rates from motor vehicle accidents are provided in table 1, and the number of youth involved in fatal motoricle accidents is reported in table 2. Age-specific rates of involvement in fatal motor vehicle accidents come from standardized nationwide reports collected by the National Highway Traffic Safety Administration's (NHTSA) Fatal Accident Reporting System (FARS). These are reported in figure 1.

The second type of facts examined are those based on self-report data about the drinking practices of 10th to 12th grade students. The data are drawn from a national probability survey of senior high school students conducted in 1978 by the Research Triangle Institute (RTI) under contract to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). This is the same data base as was reported on in *Facts for Planning* Nos. 1 through 6 (Lowman 1981, 1981/82*a*, 1981/82*b*, 1982; Lowman et al. 1982; Rachal et al. 1982). See the technical notes for further details on both the RTI and FARS data.



Standardized National Records of Fatal Motor Vehicle Accidents, 1980

National data on motor vehicle accidents show that youths—especially males—are at high risk for involvement in fatal motor vehicle accidents, and that many teenage drivers in fatal crashes have been drinking.

Young people appear to be at greater risk for death in motor vehicle accidents than do older drivers because of combined inexperience in both drinking and driving. One study in Michigan (Borkenstein et al. 1964) showed that sober adolescents were two to three times more likely to be involved in motor vehicle accidents than were drivers in their forties, and that even low amounts of alcohol consumption exaggerated the difference (Voas and Moulden 1981).

Motor vehicle accidents in 1980 were the leading cause of death among persons 15 to 24 years of age—45 deaths per 100,000 persons (table 1). Thirty-six percent of all 1980 motor vehicle fatalities were persons 15 to 24 years of age, an age group that represented only 19 percent of the general U.S. population (NHTSA 1981).

Highlights

Statistical Sources. *NCHS*, National Center for Health Statistics, estimate based on 10 percent sample of deaths in 1980; *FARS*, Fatal Accident Reporting System, National Highway Traffic Safety Administration, census of fatal accidents in 1978 and in 1980; and *RTI*, Research Triangle Institute, national probability survey of senior high school students' drinking behavior in 1978.

- Motor vehicle accidents are the leading cause of death among persons 15 to 24 years of age; 45 per 100,000 died in fatal crashes in 1980 (NCHS).
- More than 16,500 youths 15 to 24 years of age died in 1980 as a result of motor vehicle accidents (FARS).
- More motor vehicle fatalities occurred among 15- to 21-year-olds on weekend evenings between 11 p.m. and 3 a.m. than occurred any other time (FARS 1978).
- One out of every four senior high school students was at risk for alcohol-related accidents at least once during the previous year. Over half a million 10th to 12th grade students are estimated to have driven after they had a "good bit" to drink 10 or more times during the previous year (RTI 1978).
- In States with a 21-year minimum drinking age law, senior high school students consumed less alcohol than did students in States with other types of drinking age laws. Nonetheless, levels of alcohol use remained high in 21-year States. For example, 24 percent of senior high students in 21-year States drank as often as once a week, only 9 percent fewer than the students in States where the minimum age was 18, 19, or 20 years (RTI 1978).
- The majority of persons involved in fatal motor vehicle accidents are males. In 1980, 77 percent of all youths 15 to 24 years old killed in motor vehicle accidents were males, as were 83 percent of all drivers these ages who were involved in fatal crashes (FARS).
- The involvement of drivers in fatal motor vehicle accidents was highest (142 per 100,000 licensed drivers) among males 19 years of age (FARS 1980).
- Senior high school students who frequently drove cars while under the influence of alcohol were more likely than other students to be male, to be in the 12th grade, to get lower grades, to have had their first drink before 12 years of age, to get drunk at least once a week, to drink hard liquor, to drink in unsupervised settings such as cars at night and teenage hangouts, to get into trouble with their families over their drinking, and to believe they had some kind of problem with drinking. They also tended to be more tolerant of problem behavior and to be less religious than other students (RTI 1978).

Moreover, twice as many youths 15 to 24 years of age were drivers in fatal crashes than actually died in motor vehicle accidents (table 2).

Males at highest risk. The majority of young drivers and victims in fatal motor vehicle accidents were males. Males under 25 years of age in 1980 comprised only 11 percent of all licensed drivers (Federal Highway Commission 1981: table DL-20), but were involved in 31 percent of all fatal motor vehicle accidents and in 47 percent of single vehicle fatal accidents occuring at night (Cerelli 1982: tables 23-26). Of the 23,620 drivers 15 to 24 years of age involved in accidents in 1980 in which a fatality occurred, 83 percent were males (table 2). There were 16,589 motor vehicle fatalities (drivers and other victims) in this age group, and over 75 percent were males. Most of those killed were drivers; of the 10,720 drivers who died in fatal accidents in this age group, 85 percent were males (table 2).

The magnitude of involvement in fatal accidents is considerably greater for young males than for young females, as shown in figure 1. In 1980, the number of 16-year-old male drivers involved in fatal motor vehicle accidents was nearly three times that of females the same age. This difference between adolescent boys and girls steadily increased. By 20 years of age, male drivers were involved in fatal crashes five times more often than were females in the same age group.

Male and female involvement in fatal crashes also differs markedly in pattern. For males, fatal accident driver-involvement rates rose steadily from age 16, peaking at age 19 and then gradually dropping. For young females, the fatal accident driver involvement rate steadily declined from age 16, with only a slight rise at 19 years of age.

These 1980 age-specific rates show that young males are at a much greater risk of involvement in fatal motor vehicle accidents than are young females and that the risk increases with age up to 19 years. Young females, on the other hand, appear to become increasingly safe behind the wheel as they approach 24 years of age. However, females at age 19 appear to be at slightly increased risk, despite their overall lower and decreasing rate of fatal accident involvement.[1]

Reasons for the substantial differences in male and female involvement in fatal motor vehicle accidents are unclear. The number of hours spent driving no doubt increases with age for both sexes; at the same time, however, they are gaining more experience as

Table 1. Death rates from motor vehicle accidents distributed by 10-year age groups, 1980

Age groups	Deaths per 100,000
Under 1 year	7.6
1-14 years	8.7
15-24 years	45.0
25-34 years	30.9
35-44 years	19.6
45-54 years	21.3
55-64 years	18.1
65-74 years	21.7
75-84 years	33.0
85 years and over	24.8
All ages	24.4

Note: Data is from a 10 percent national sample of deaths collected by the National Center for Health Statistics, and presented in table 8, "Age-Specific and Age-Adjusted Death Rates for 15 Leading Causes and Selected Components: United States, 1979 and 1980." (National Center for Health Statistics 1981).

Table 2. Number of 15- to 24-year-olds in fatal motor vehicle accidents and percentage of males involved, 1980[1]

	A		B		C	
	Total drivers involved in fatal crashes		Total motor vehicle fatalities		Total driver fatalities	
Age	N	Percent Males	N	Percent Males	N	Percent Males
15	282	74.8	581	60.4	151	83.4
16	1,485	76.7	1,266	67.2	652	76.1
17	2,218	79.5	1,677	70.4	946	81.2
18	2,883	83.4	2,175	75.7	1,324	85.1
19	3,216	83.7	2,186	79.4	1,416	86.2
20	2,963	84.4	1,922	80.2	1,331	86.9
21	2,806	83.3	1,884	78.3	1,306	84.8
22	2,774	84.4	1,796	80.5	1,317	86.0
23	2,624	85.0	1,666	80.7	1,278	85.7
24	2,369	83.5	1,436	79.2	1,049	83.5
15-24 years	23,620	83.0	16,589	76.6	10,720	84.5

[1]The numbers of drivers and fatalities reported above were provided by the National Highway Traffic Safety Administration (NHTSA 1981) from the Fatal Accident Reporting System for 1980. Motor vehicle accidents refer to all accidents on public roads involving any type of motor vehicle including trucks, motorcycles, passenger cars, ambulances, buses, etc.

Notes:

Column A. All drivers of motor vehicles involved in crashes in which at least one fatality resulted, including fatalities to pedestrians or pedicyclists (see NHTSA 1981 for details).

Column B. All persons killed as a result of motor vehicle accidents who were passengers or drivers; excludes pedestrains and pedicyclists killed by motor vehicles.

Column C. All drivers in motor vehicle accidents who themselves died within 30 days as a result of the accident.

drivers. Previous analyses of data from the Research Triangle Institute's national probability survey suggest that differences in patterns of alcohol consumption may explain some of the differences in fatal accident involvement. Senior high school boys were found more likely to consume large amounts of alcohol more frequently than girls. For example, 24 percent of 12th grade boys reported they drank at least five drinks on each occasion at least once at week, while 10 percent of senior girls reported comparable levels of weekly heavy drinking (Lowman 1981: table 1). The discrepancy between boys' and girls' levels of alcohol consumption characterized students in all grades of senior high school, but increased with each ascending year, in a manner analogous to the discrepancy between boys' and girls' involvement in fatal motor vehicle accidents.

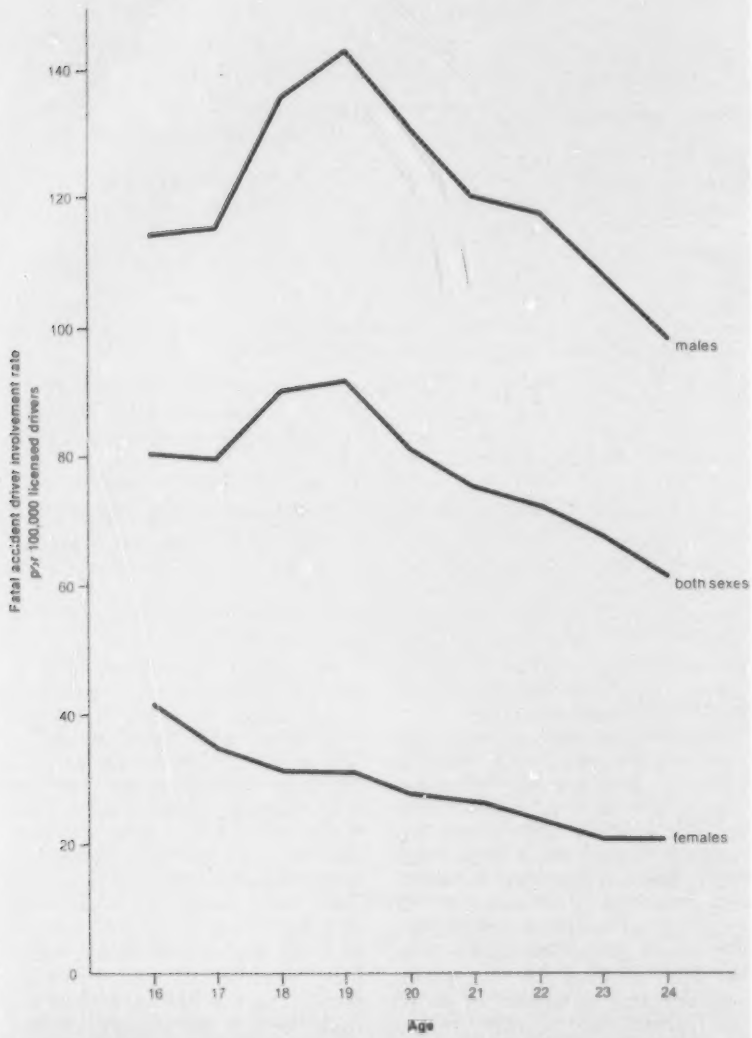
Blood alcohol concentration (BAC). Unfortunately, measures of blood alcohol concentration (BAC), or percentage by weight of alcohol in the blood, are not available for all drivers involved in fatal motor vehicle accidents. BAC test results are known for only 29 percent of the drivers in 1980 fatal crashes (NHTSA 1980: figure 43). Young drivers were neither over- nor under-represented in BAC testing. Approximately 40 percent of drivers with known BAC test results were 15 to 24 years of age, a proportion comparable to the 38 percent of drivers these ages who were involved in fatal crashes (NHTSA 1980: figures 39 and 43).

Among the 7,454 drivers 15 to 24 years of age who were involved in fatal motor vehicle accidents and whose BAC levels were known, *54 percent* had BACs of 0.10 percent or more (NHTSA 1980: figure 43), the legal level designating intoxication in most States. This finding is difficult to evaluate. If BAC testing occurred primarily when alcohol involvement was suspected or known, then the resulting statistics would disclose very high levels of alcohol involvement. However, BAC reporting requirements and practices vary from State to State and from locality to locality. Consequently, the national FARS data on blood alcohol are difficult to interpret because they are subject to a number of sources of bias (NHTSA 1978).

Estimates based on FARS data

[1] For males, fatal accident driver involvement rates rose from 114 per 100,000 among 16-year-old licensed drivers, to peak at 142 per 100,000 among 19-year-old licensed drivers. The rate then gradually dropped to 97 per 100,000 among 24-year-old licensed drivers. For females, the rate steadily declined from 42 per 100,000 licensed drivers at age 16, to 21 per 100,000 licensed drivers at age 24. (See technical notes on FARS for data sources used to calculate the rates.)

Figure 1. Sex and age-specific fatal accident driver involvement rates, 1980



Note: The fatal accident driver involvement rate equals the number of drivers involved in fatal motor vehicle accidents per 100,000 licensed drivers. Drivers include the 55 percent of 16- to 24-year-olds who were survivors of motor vehicle accidents in which at least one fatality occurred as well as the 45 percent who were themselves fatalities (Fatal Accident Reporting System 1980; see technical notes for details on data sources used to compute the rates).

drawn from 29 States in which BAC testing was most complete indicate less extensive heavy alcohol use than do the national data. Nonetheless, heavy alcohol involvement among many drivers in fatal crashes was still evident. Based on the 29-State 1980 FARS data, it is estimated that *29 percent* of 15- to 19-year-old drivers and *37 percent* of 20- to 24-year-old ones had BACs of 0.10 percent or more (Cerelli 1982: table 30).

More accidents on weekends. Self-report data collected in a household survey in Boston during 1974 showed that persons 18 to 25 years of age drank significantly more alcohol on Fridays and Saturdays than did persons of any other ages. However, on other days this was not the case (Harford and Gerstel 1981). Extensive weekend social activities involving alcoholic beverage consumption probably account for the distinctive temporal pattern of fatal crashes observed among young people (see Voas and Moulden 1980, figures 4-5 to 4-7). FARS data from 1978 disclosed a sharp peak in motor vehicle fatalities among 15- to 21-year-olds at about seven per hour at 1 a.m. on weekends. The fatality rate in this age group was highest between 10 p.m. and 3 a.m. on weekends. Weekday fatalities peaked at slightly over two per hour at 11 p.m. on weekdays. This distinctive pattern became even more pronounced in the 22- to 44-year age group, in which motor fatalities peaked at eight per hour at about 2 a.m. on weekends and occurred at a rate of three per hour between 9 and 11 p.m. on weekdays. Among persons 45 years of age and older, however, while there was a weekend swell in fatalities, there was no steep peak as there was among younger age groups.

Estimates of BAC levels based on the 29-State 1980 FARS data support the assumption that the majority of drivers involved in nighttime single vehicle fatal accidents have been drinking. In 1980, an estimated 64 percent of drivers involved in nighttime single vehicle fatal crashes had BAC levels of 0.10 percent or greater, twice that of drivers involved in daytime single vehicle fatal crashes (Cerelli 1982: table 15). The level of alcohol involvement among young drivers in fatal accidents at night on weekends was comparable. An estimated 62 percent of males 24 or younger had BAC levels of 0.10 percent or greater and 79 percent showed some evidence of alcohol use (Cerelli 1982: table 25).

Self-Report Data on Drinking by Senior High Students, 1978

Records of death provide vital statistics on causes of death, the magnitude of fatalities, and changes over time. These direct our attention to the groups most likely to be affected by lethal conditions. Complementary information on the degree of adolescent *exposure to risk* of involvement in alcohol-related crashes is provided by self-report data collected in 1978 by the Research Triangle Institute (RTI) in a national probability survey of 10th to 12th grade students. The RTI data furnish answers to two important questions. Are minimum drinking age laws related to teenage alcohol use? and What are the characteristics of senior high school students who frequently drive under the influence of alcohol?

Minimum drinking age laws. Recent research on drinking age laws has focused on the short-term effects of changing the minimum drinking age. Maisto and Rachal (1980) used the nationally representative RTI data base to examine the "longer-term relationship between (minimum drinking age) laws and the behavior patterns they are designed to control." They classified students from the 29 States surveyed by RTI in 1978 according to the minimum drinking age in their State of residence. Minimum drinking age laws were divided into three categories: (1) *21-year States*, those with a 21-year minimum drinking age for all alcoholic beverages; (2) *18- to 20-year States*, those specifying an 18- to 20-year minimum drinking age for all alcoholic beverages; and (3) *mixed States*, those with different minimum drinking ages for different types of alcoholic beverages, usually 21 years for hard liquor and 18, 19, or 20 years for beer and wine. (See technical notes for further details.)

Maisto and Rachal found that 10th to 12th grade students who resided in States with a minimum drinking age of 21 years used less alcohol than did students in other States. However, their analysis also shows that a conservative drinking age law does not eliminate illegal drinking by senior high school students. Alcohol use was found to be extensive nationwide. (Tests showing that the 1980 Maisto and Rachal findings are statistically significant, as well as evaluations of their validity, can be found in the original study.)

According to Maisto and Rachal, 30 percent of students who lived in States with a 21-year minimum drinking age law were alcohol abstainers—10 to 11 percent more than in States with other types of minimum drinking ages. On the other end of the spectrum, 24 percent of students in 21-year minimum drinking age States drank once a week or more often. This was 9 percent fewer than in 18- to 20-year States and 5 percent fewer than in mixed States. Ten percent of students in 21-year States reported they had gotten drunk as often as once a week during the previous year—only 5 percent fewer than in 18- to 20-year States and 4 percent fewer than in mixed States.

The percentage of students who combined drinking and driving did not vary greatly. Nineteen percent of 10th to 12th graders in 21-year States reported they often drank when they drove around or sat in cars at night; this was only 4 percent fewer than in 18- to 20-year States and 5 percent fewer than in States with mixed drinking ages.

It is interesting to note that 14 percent of students who lived in 21-year States reported that they disapproved of alcohol use, twice as many as in States with less restrictive drinking age laws.

Characteristics of students at risk for driving under the influence (DUI). Five percent of students in the RTI survey reported that they drove cars after they had had a "good bit" to drink at least 10 times or more during the previous year. Extrapolated to the Nation, this means an estimated half-million senior high school students in 1978 were probably at high risk for involvement in fatal motor vehicle accidents. This may be a conservative estimate, since students reporting less frequent DUI incidents were also at risk.

Who were these 10th to 12th grade students at recurring risk for alcohol-related motor vehicle accidents? Did

Table 3. Characteristics of students who frequently drove under the influence of alcohol, 1978

Characteristics	Frequent DUI students (percent)	Other students (percent)
Sex		
Male	78.8	44.5
Female	21.2	55.5
Grade		
10th	11.3	34.2
11th	36.2	34.3
12th	52.5	31.4
School grades		
Excellent (As and Bs)	20.3	38.7
Good (Bs and Cs)	62.1	54.0
Below average (Cs, Ds, and Fs)	17.5	7.3
Age at first drink		
Never had a drink	0.0	11.6
Under 12 years	33.1	14.2
12 to 14 years	48.3	41.9
15 years and over	17.6	32.3
Number of times students got drunk during the previous year		
None	0.9	43.1
1 to 5 times	5.9	30.2
6 times to twice a month	27.9	16.4
Once a week or more often	65.3	10.3
How often students drink beer, wine, or liquor when driving around or sitting in cars at night		
Never	1.4	53.1
Sometimes	17.9	27.7
*Often	80.7	19.2
How often students drink beer, wine, or liquor when at places where teenagers hang around and their parents or other adults are not present		
Never	4.2	43.9
Sometimes	14.9	27.8
*Often	80.9	28.3
Number of times students got into trouble with family because of their drinking during the past year		
None	49.5	81.1
Once	12.6	11.4
2 to 3 times	18.9	5.4
4 times or more	19.0	2.1
Students perceive their drinking to have been a problem during the past year		
Don't drink or not a problem	76.6	94.0
A mild problem	16.4	5.1
More than a mild problem	7.0	0.8

*Percentages of students who "often" drink when in a setting combine students reporting they "frequently" drank there with those who reported they drank there "most of the time."

Note: The "frequent DUI students" refer to 222 students who responded that they had driven when they had a "good bit" to drink 10 or more times during the previous year. "Other students" refer to the remaining 4,523 students in the 1978 RTI national probability sample of 10th to 12th grade students who responded to the question (Rachal et al. 1980*a* or 1980*b*). Although the statistics are useful for bringing into sharp relief contrasts between the two groups, the small sample size for the "frequent DUI" category means those percentages should not be used to make estimates.

they differ from other students? The distributions in table 3 compare those teenagers who were frequent drinking-drivers with other students along a number of dimensions. Students who responded "10 times or more" to a question asking how often in the previous year they had driven after having a "good bit" to drink are referred to in table 3 as those who frequently drive under the influence (DUI).

"Good bit" to drink is a relative concept with no objective measure for degree of intoxication. It cannot be assumed therefore, that a "good bit" to drink means drunk. The fact that 65 percent of students in the frequent DUI group also reported they got drunk at least once a week, however, makes it probable that a "good bit" to drink was interpreted to mean a substantial amount of alcohol.

As table 3 shows, the majority of students who frequently drove under the influence were males and seniors. More than twice as many in the frequent DUI category got below average grades (Cs, Ds, and Fs) than did other students. One out of three students who were in the frequent DUI category had his or her first drink, not just a sip or taste, of alcohol before the age of 12 years, as compared with one out of seven of the other students surveyed.

Six times as many of the students who reported frequent DUI also reported a high frequency of drunkenness, compared with other students. Sixty-five percent of the frequent DUI group got drunk at least once a week. This suggests that the estimated half-million students who frequently drank and drove in 1978 may have driven under the influence of alcohol many more than 10 weekends during the preceding year.

Eighty percent of the 222 senior high school students who frequently drove under the influence of alcohol reported they often drank when they drove around or sat in cars at night, while only 20 percent of other students did. Over 80 percent of the frequent DUI group also reported they often drank beer, wine, or liquor in other unsupervised teenage hangouts, as compared with 28 percent of all other students.

Although few students perceived

their drinking to have been a problem during the previous year, nearly four times as many students who frequently drove under the influence of alcohol reported their drinking to be some kind of problem as did other students (23 percent as compared with 6 percent). Over one-third of the frequent DUI group reported they had gotten into trouble with their families about their drinking at least two times during the previous year, nearly four times as often as the other students did.

There were no marked differences in the socioeconomic status of students who frequently drove under the influence of alcohol at least 10 times during the previous year as compared with all other students. However, they did tend to be less religious than other respondents and to be more tolerant of problem behavior.

More extensive reports of the RTI findings based on these dimensions can be found in *Facts for Planning* No. 3 (Lowman 1980/81*b*), No. 4 (Rachal et al. 1982), and No. 6 (Lowman 1982).

Implications

National alcohol, health, and motor vehicle accident statistics have been used to show that alcohol consumption, driving under the influence of alcohol, and involvement in alcohol-related accidents are extensive among youth (especially males), many of whom are under the legal drinking age.

The RTI study on the relationship between the State minimum drinking age laws and the drinking practices of 10th to 12th graders indicates that a 21-year minimum legal drinking age is related to less alcohol use by teenagers. However, the data also show that teenage drinking is extensive even in Stateshq 21-year laws, although less so than in ones with lower drinking age laws. Further, the nature of the relationship between legal drinking age and levels of teenage alcohol use is unclear. Laws may be artifacts of social customs and values rather than shapers of them.

The RTI study suggests that raising the legal drinking age to 21 years will not eliminate underage alcohol consumption. Although the prevalence of alcohol use appears somewhat lower in 21-year States, there remains in all States an urgent need to develop prevention programs on the local level as well as through State-level control policies that impact alcohol use among youth.

The FARS and RTI data show that among youth it is the older adolescent males who are at higher risk for alcohol-related involvement in motor vehicle accidents. Among both boys and girls, 19 appears to be a particularly vulnerable age. For most youth, this is the first year out of high school and also the first year as legal adults. Increased freedom and experimentation accompanied by increased alcohol use—regardless of State drinking age—may explain the peak involvement in fatal crashes at 19 years.

RTI findings on the social characteristics of senior high school students who reported that they frequently drove under the influence of alcohol suggest that intervention and control measures may be needed in addition to preventive efforts. Comparison of the subgroup of students at high risk for DUI with all other students sampled suggests they were less likely to be receptive to rational, preventive educational approaches. Indeed the data considered here suggest that youth at high risk for DUI—particularly high school seniors and 19-year-old males—may be a hard-to-reach group for control and intervention as well as prevention measures.

Most studies of drinking among youth are confined either to high school students or to college students. The drinking-driving data on youth considered here confirm the serious need for a single population study of 16- to 24-year olds—both students and nonstudents—in order to determine the nature of transformations in drinking practices that take place between late adolescence and early maturity. Such knowledge will aid the development of effective policies and programs to modify the social context, behavior, and values that lead to the high involvement of young drivers in fatal motor vehicle accidents.

Technical Notes

Fatal Accident Reporting System. The Fatal Accident Reporting System of the National Highway Traffic Safety Administration (NHTSA) has collected data annually since 1975 on all fatalities that occurred within 30 days after involvement in motor vehicle accidents on roads open to the public. The data are collected by FARS analysts in State agencies from a number of State sources (for example, police accident reports, death certificates, and emergency medical service

reports). The State analysts enter data directly into NHTSA's computerized central data file, using a standardized format for registering information on over 90 different attributes of fatal accidents, of the drivers and vehicles involved, and of persons fatally injured in them.

States vary with respect to laws and procedures for collecting information on fatal accidents. About half of the States legally require that tests of blood alcohol concentration (BAC) be administered to fatally injured drivers. Surviving drivers were tested only 19 percent of the time (NHTSA 1981). In 1980, BAC tests were administered to only 37 percent of the drivers involved in fatal motor vehicle accidents and were actually reported for only 29 percent of them. Since BAC data are based on neither a random sample nor a census, it is unclear how representative they are.

The fatal accident driver involvement rate (figure 1) represents the total number of drivers involved in fatal accidents per 100,000 licensed drivers. Two data sources were used by the author to develop the rate and figure 1, showing its national distribution among youth by sex and year of age. One source was the 1980 FARS census of all drivers involved in fatal motor vehicle accidents (NHTSA); the other was the Department of Transportation's (DOT) national census of drivers' licenses in 1980 as reported in the table entitled "Distribution of licensed drivers by sex and percentage in each age group and relation to population, 1980" (NHTSA 1980).

Research Triangle Institute (RTI) 1978 National Probability Survey of Adolescent Drinking Practices. RTI used a questionnaire to collect nationally representative information on trends in drinking practices among 10th to 12th grade students related to demographic, attitudinal, and personality characteristics; the frequency, quantity, contexts, and consequences of drinking; the perceived or reported influence of friends and peers; deviant or antisocial behavior; and the use of drugs in addition to alcohol.

Methodology. A three-stage stratified sampling strategy was employed. The first stage involved selecting a probability sample of all counties in the 48 contiguous States and the District of Columbia, stratified by geographic region and community size. A second-stage probability sample was taken of all high schools in each county selected. At least one high school was chosen from each county and more than one from large counties. Finally, a probability sample of homerooms in each grade in school, was taken from the sample of high schools selected in the second stage. Questionnaires were self-administered by student groups in homerooms or classes. Instructed and supervised by RTI-trained staff, students were assured that their responses would be anonymous and confidential.

Some of the original, randomly selected sampling units were replaced, using probability measures. The "overall participation rate" in the final adjusted sample is 85 percent (the proportion of schools participating multiplied by the proportion of students participating).

The RTI sample was not representative of all adolescents in the Nation. Neither high school dropouts nor absentees were sampled. Both of these subgroups may manifest different drinking patterns from those that characterize the in-school high school students. Further, inner city students and members of the ethnic groups other than "white" or "black" were probably undersampled. Nonetheless, the sample is representative of the majority of the Nation's senior high school students. More detailed discussions of sampling validity are contained in the RTI final report (Rachal et al. 1980*a*, 1980*b*).

Statistics. In *Facts for Planning* Nos. 1, 2, 3, 5, and 6, weighted percentages were used in order to estimate the number of youths in the Nation in 1978 who were drinkers. For convenience in analytical procedures, analyses in *Facts for Planning* No. 5 were based on unweighted sample values.

The statistics reported in this article from the Maisto and Rachal 1980 study are based on sample values. Sample percentages are used to describe characteristics of students who frequently drove under the influence of alcohol because the subset is too small (222 persons) to represent the Nation with the same accuracy that weighted percentages based on the larger RTI sample does.

In general, percentages based on the weighted and unweighted RTI national probability samples (1974 and 1978) are comparable, indicating that the RTI samples are highly representative of the national population of high school students on which they are based (Rachal et al. 1980*b*). Percentages are based on all cases that have analyzable data, not the total samples.

States in the 1978 RTI sample. In the spring of 1978, RTI sampled senior high school students in 30 States randomly selected from the 48 contiguous States in the continental United States. Twenty-nine of these were included in the Maisto and Rachal (1980) minimum drinking age law study. Michigan was excluded because it lowered

its minimum drinking age shortly after the RTI survey was conducted. The 29 States in the study were classified on the basis of State minimum drinking age laws as of May 1, 1979 (Maisto and Rachal 1980: p. 164); *21-year States* (21 years for all alcoholic beverages) included California, Kentucky, Missouri, Oklahoma, Oregon, Pennsylvania, Utah, and Washington; *18- to 20-year States* (18 to 20 for all alcoholic beverages) included Alabama, Connecticut, Florida, Louisiana, Maine, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, Tennessee, Texas, and Vermont; *mixed States* (different ages for different alcoholic beverages, and usually 21 for hard liquor and 18 to 20 for beer and wine) included Colorado, Illinois, Mississippi, North Carolina, Ohio, South Carolina, and Virginia.

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*This report is available for purchase from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

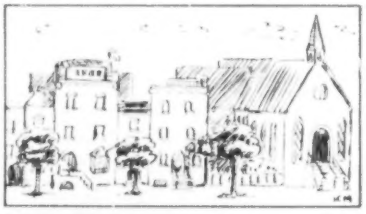
NewsNotes

Black Youth Programming Guide Available

A *Guidebook for Planning Alcohol Prevention Programs for Black Youth* contains a wide range of ideas on starting programs to prevent alcohol problems among black youth. The 200-page manual describes the steps involved in starting a prevention program, including mobilizing interested groups, getting multiple agency support through networking, determining the issues that are of greatest concern to a community, writing a grant proposal, and holding a prevention workshop. It also describes the critical process of involving youth as partners in the program and looks at the culture-specific needs of minority communities. The *Guidebook* has three appendices that contain program planning materials, community workshop materials, and a glossary and references.

The *Guidebook*, developed by the NIAAA's National Clearinghouse for Alcohol Information, is the outgrowth of several years of interaction with community and church groups, State and local alcohol treatment and prevention groups, and black youth. This has included conferences in three sites to identify community needs and resources and to discuss strategies for setting up primary prevention programs aimed at black youth.

The *Guidebook* is designed to serve as a reference publication for alcohol prevention programs that work with black youth; a tool for involving black church groups in alcohol problem prevention; and a resource for a wide range of existing community groups involved in working with black youth. Single copies of the *Guidebook* (order no. BK 91) are available at no charge from the NIAAA National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.



Community Brochures

Ways in which alcohol and drug programs can raise community awareness about alcohol problems are explored in a brochure prepared by the Charlotte (NC) Council on Alcoholism (CCA). Over the past 2 years, CCA has distributed more than 20,000 of the pamphlets to community leaders, human service providers, and interested citizens.

The pamphlet describes alcoholism and lists resources and agencies in the area where individuals and their families can seek help. Included are Alcoholics Anonymous, Al-Anon, and the Salvation Army, as well as local treatment centers, clinics, and detoxification facilities. The council is also distributing a brochure, "Alcohol Abuse Statistical Information," to interested citizens.

For further information, contact Jim Kelley, Mecklenburg County Seventh Street Detoxification Center, 1325 East Seventh Street, Charlotte, NC 28204.

New Journal

Revista Italiana di Alcologia, a new alcohol journal produced by the Societa Italiana di Alcologia (SIA), will become its official publication. *Revista Italiana di Alcologia* will address the study of intervention and the medical, psychological, sociological, economical, agricultural, and legal aspects of alcoholism. For more information, contact Dr. Daniela Orlandini, Societa Italiana di Alcologia, Via Cavazzana, 26-35100 Padova, Italy.

Monographs Published

Two new volumes in the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) research monograph series are now available from the U.S. Government Printing Office (GPO). Research Monograph No. 6 *Development of Animal Models as Pharmacogenetic Tools* surveys the literature in pharmacogenetics generally and in behavioral pharmacogenetics specifically. A copy of the monograph can be obtained for $7 by requesting stock number 017-024-01124-0. Research Monograph No. 8 *Occupational Alcoholism: A Review of Research Issues* reviews the state of the knowledge, discusses research issues, and makes recommendations for future research in the area of occupational alcoholism. A copy can be obtained for $9.50 by ordering stock

ResearchReports

number 017-024-01126-6.

Both of these monographs can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Family Coalition Seeking Information

The Family Resource Coalition, a grassroots federation of family support programs in the United States, is seeking information for a national clearinghouse on family-related issues, including alcohol abuse. The coalition, located in Chicago, is devoted to building program networks at the State level, promoting the exchange of program information, and publicizing the value of community-based family support.

The coalition clearinghouse will include comprehensive materials on family support programs, technical assistance resources, and research related to family support. The coalition is made up of programs that range from cooperatives run by parents to programs associated with hospitals and social service agencies, from volunteer programs to programs with a large paid staff, and from neighborhood support groups to parent education classes.

For further information, contact Linda Lipton, Family Resource Coalition, 230 North Michigan Avenue, Suite 1624, Chicago, IL 60601.

Most people working in the alcohol field are aware that heredity plays a role in the development of alcoholism. Now, a 10-year research study conducted in Sweden takes a new look at the risks the son or daughter of an alcoholic parent must face and examines the interaction of hereditary and environmental factors. The study offers the intriguing suggestion that there may be at least two different types of inherited alcohol problems, and that one of these is more influenced by environmental risk factors and is thus more amenable to intervention. The study shows for the first time that women inherit alcohol problems, usually from their mothers, and suggests that modeling of parental drinking may not be an important factor in the development of alcohol problems.

An important French study shows that propranolol, a drug widely used to treat arrhythmias, angina, hypertension, migraine, and heart attacks, can lessen mortality from gastrointestinal bleeding in patients with cirrhosis.

From Father and Mother to Son and Daughter

Two different forms of inherited alcohol problems that have distinct genetic and environmental causes have been identified by researchers working at the National Alcohol Research Center at Washington University in St. Louis, Missouri, and the Umea University School of Medicine in Umea, Sweden. The National Alcohol Research Centers are supported by grants from the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

One type of alcohol problem is called male-limited because it tends to be passed only from fathers to sons. It is highly hereditary regardless of environment and limited to men whose natural fathers have records of extensive treatment for combined alcohol abuse and criminal behavior.

The other is referred to as milieu-limited because of the role environment plays in the frequency and severity of its development. It affects both men and women and is usually associated with mild alcohol abuse and minimal criminal behavior on the part of the natural parents.

The research was reported in two separate articles in *Archives of General Psychiatry* (Vol. 38, No. 8, pp. 861-868; Vol. 38, No. 9, pp. 965-969). The findings are based on an extensive examination of medical and social records of 862 males and 913 females born in Stockholm, Sweden, from 1930 to 1949 and subsequently adopted. Sweden was seen as an ideal site for an adoption study because adoption records are more extensive there than in other countries. The 10-year study began in 1970.

The study clearly shows that both hereditary and environmental factors play a role in the development of alcoholism. The researchers found that, if the natural parents of the adopted children were alcoholic, the children ran a greater risk of becoming alcoholic despite being raised by nonalcoholic adoptive parents. However, if the natural parents were not alcoholics and the adoptive parents were, the risk

was not increased.

The current study, which points strongly to the role of inheritance in development of alcohol problems, is also the first to show that women as well as men inherit such problems, according to C. Robert Cloninger, M.D., professor of psychiatry and genetics at the Washington University School of Medicine, who became involved in the data analysis 3 years ago.

Data collected on each of the adoptees and their biological and adoptive parents came from records of treatment or other intervention for problems, criminal behavior, and occupational status. Additional information gathered about the adoptees included number of temporary placements, days spent with the natural mother, days of hospital care prior to placement, days of foster care, and the size of the town in which the adoptive family resided. Of the adoptees studied, a total of 151, or 17.5 percent, had some record of alcohol problems.

The researchers used the information not only to show that alcohol problems were inherited, but also to distinguish two different types of inherited problems and to examine how environment influenced risk. "It's one of the few studies to clearly separate environment and genetics and to look at how they interact with one another," said Cloninger.

The male-limited form of alcohol abuse accounted for only about 24 percent of the adopted men with alcohol problems in the study. Passed from father to son, this type of alcohol abuse was highly hereditary despite adoptive environment. Drinking problems of the fathers of this group began early in life—usually in adolescence—and recurrent abuse often interfered with work and marriage and led to crimes of violence such as assault and wife beating. Sons of this type of alcoholic faced a ninefold increase in risk. About 18 percent of the sons of men with this type of alcoholism developed alcohol problems, compared with about 2 percent of the general population, Cloninger said.

Although environmental factors seemed to have little effect on the risk of developing this type of alcohol problem, they may have influenced the severity of the problem. The natural fathers of these adoptees had a record of extensive treatment for alcohol problems while the sons had a record of recurrent problems but not treatment, indicating, possibly, a milder form of illness, the researchers said. Their placement into middle-class adoptive homes have moderated the severity, Cloninger said. On the other hand, the lack of a treatment record and the relatively mild problems may be due to the relative youth of the adoptees in comparison with their fathers at the time of the study, or to the inheritance of fewer of the genes that increase susceptibility to alcoholism, he said.

A much more common type of alcohol problem, the milieu-limited form, affected 76 percent of the men and all of the women with alcohol problems whose natural parents had alcohol problems. Although susceptibility was hereditary, environmental factors had significant impact on both frequency and severity of the problem, the researchers said.

The risk among the male adoptees of developing this type of alcohol problem varied from 13 to 26 percent, depending upon environment. Although "alcohol abuse is mild in most such cases and usually does not require treatment . . . more severe disability requiring hospital care may occur in susceptible sons who are exposed to particular postnatal environments, especially sons from the sociocultural background associated with low occupational status," the researchers said. Other environmental factors that increased risk among the male adoptees were longer hospital care prior to placement, more contact with biological mothers, and an older age at placement in adoptive homes (average age at placement was 8 months).

The biological fathers of these men had a history of heavy drinking that began in their 20s or 30s, and gradually progressed to a state of physical dependence in middle age. The fathers may have had medical problems associated with their drinking, but were usually able to maintain jobs and families. Problems were mild, criminal behavior was minimal, and often there was no history of treatment. The natural mothers of adoptees with this type of problem, in contrast with the mothers of those with the male-limited form, sometimes also had a history of mild alcohol problems and convictions for minor crimes.

This milder milieu-limited type of alcohol problem also appeared to be inherited by women, most often from their mothers. Among adopted daughters whose natural parents had alcohol problems, 6.7 to 7.7 percent (depending on environment) developed alcohol problems compared with 2.3 percent in the general population.

Although both fathers and mothers with mild forms of problems had daughters who became alcoholic, daughters whose mothers had problems were much more susceptible.

If the biologic mother had alcohol problems, daughters were four times more likely than the general population to develop alcohol problems. If only the father was alcoholic, there was no significant increase in the incidence of daughters who had alcohol problems. "Here we have demonstrated for the first time . . . the importance of maternal inheritance in alcoholic women," the researchers said.

Characteristics of the natural mother, in addition to alcohol problems that predisposed an adopted daughter to alcoholism, were low occupational status and relatively minor legal offenses. Significant environmental factors that increased the risk of alcohol problems among the adopted women included lower occupational status among adoptive fathers, placement in rural homes, increased contact with biological mothers prior to placement, and shorter hospital care.

Interestingly, the investigators found that, for both types of alcohol problems studied, male and female children raised by alcoholic adoptive parents showed no increased risk in comparison with those raised by nonalcoholic adoptive parents. Modeling of parental drinking behavior thus may not be an important factor in the development of alcoholism, Cloninger said.

Identification of these two different subgroups of alcohol problems has important implications for future study, he added. Different types of alcohol abusers can be studied separately and compared to give a clearer picture of the underlying neurobiological and sociocultural differences that contribute to the development of alcoholism, Cloninger said.

For further information, contact C. Robert Clonginger, M.D., Department of Psychiatry, Jewish Hospital, P.O. Box 14109, St. Louis, MO 63178.

Bleeding Halted by Drug

Propranolol, a drug widely used in the United States to treat heart disease, also can prevent dangerous recurrent gastrointestinal bleeding in persons with cirrhosis of the liver, Didier Lebrec, M.D., and colleagues of Hospital Beaujon, in Clichy, France, report (*N Engl J Med* 305:1371-1374, 1981).

About one-third of deaths in cirrhotic patients are due to hemorrhage and there is no accepted long-range treatment for this condition, although doctors sometimes perform surgery to relieve pressure in the large veins leading to the liver. Since propranolol decreases pressure in these veins, it was hoped that continued long-term administration of the drug might help prevent recurrent gastrointestinal bleeding.

In the recent study, patients hospitalized with cirrhosis and gastrointestinal bleeding but in otherwise good condition were randomly assigned to one of two treatment groups. Thirty-eight patients received oral propranolol in doses that reduced the heart rate by 25 percent, and 36 patients received a placebo that looked like propranolol, but had no effect.

One year later, 96 percent of the patients in the propranolol group were free of rebleeding, while in the placebo group, 50 percent had no rebleeding. Two patients in the propranolol group died of infection and liver failure shortly after the study began; in the placebo group, four patients died of massive rebleeding.

The investigators conclude that "because of its efficacy and lack of serious side-effects, continuous administration of oral propranolol at doses that reduce the heart rate by 25 percent can be recommended for prevention of rebleeding in patients with cirrhosis who are in otherwise good condition." They cautioned, however, that their experience was limited to patients in good condition who have taken the drug 1 year or less.

Propranolol is the most widely used cardiovascular drug in the United States and has been approved for the treatment of arrhythmias, angina, hypertension, and migraine. Recently, the National Heart, Lung, and Blood Institute recommended approval of the drug for the treatment and prevention of heart attacks.

—Nancy Johnson
Staff writer

The Occupational Arena

Senate Hearing on Alcohol, Drug Abuse, and Productivity

A joint hearing of the Employment and Productivity Subcommittee and the Alcoholism and Drug Abuse Subcommittee of the U.S. Senate listened to testimony on the value of employee assistance programs (EAPs) to industry.

William E. Mayer, M.D., Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), cited ADAMHA's many contributions to the alcohol and drug abuse field and its historical contribution to the development of employee assistance programming.

Former Department of Health, Education, and Welfare Secretary Joseph A. Califano, Jr., cited statistics on the impact of alcohol and drug abuse based on a study he conducted for New York Governor Hugh Carey. He testified that alcohol is the substance of most pervasive abuse, and called alcoholism one of America's four major diseases. Califano stated that more EAPs have not been established for four reasons: (1) the stigma of the disease (companies don't want to admit they employ "drunks"); (2) the assumption that alcoholics are screened out in preemployment interviews and reference checks; (3) the lack of knowledge of ways to finance treatment; and (4) the lack of understanding of the benefits of such programs.

Other testimony came from representatives of EAPs at the General Motors Corporation (Indianapolis diesel plant), the Stroh Brewery Company, the Amalgamated Clothing and Textile Workers Union, and ALMACA. Stress management and health promotions programming was addressed by the Adolph Coors Company. Also testifying were Burford Culpepper, M.D., assistant medical director of E.I. DuPont DeNemours and Company; Michael R. Frost, associate director, Workforce Effectiveness and Development, U.S. Office of Personnel Management; Peter Bensinger, president of Bensinger, DuPont and Associates, Inc. (former administrator of the U.S. Drug Enforcement Administration); Dr. William Y. Rial, president of the American Medical Association (AMA); and Dr. LeClair Bissell, member of the AMA panels on Alcoholism and Physician Mortality.

Senators Dan Quayle (R-IN) of the Employment and Productivity Subcommittee and Gordon Humphrey (R-NH) of the Alcoholism and Drug Abuse Subcommittee chaired the session. Both acknowledged the growing impact of alcoholism and drug abuse in health, economic, and human terms. Senator Quayle indicated that more needs to be done to carry the message of the economic impact of alcohol and drug problems and the success stories of EAPs.

Women's Occupational Alcoholism Project Report Available

The Women's Occupational Alcoholism Demonstration Project funded by the NIAAA at three sites (California, New England, and New York) has been completed. The objectives of this project were:

- In phase I, to examine alcoholism in selected work settings in terms of frequency of occurrence of alcohol problems among female employees, male-female differences, and special needs among the female work force; success of the existing employee alcoholism program was also to be assessed.

- In phase II, to design components that could be added to an existing EAP, which could address the special needs of a targeted female employee group.

- In phase III, to measure the changes that resulted from the addition of a special component designed for female employees, and to establish parameters by which future EAP efforts seeking to assist women employees could be evaluated and improved.

Though the Phase I results at the three sites differed somewhat, there were some consistencies in their recommendations of interventions designed to reduce problem drinking and alcoholism among women in the workplace. The special components for women were to include the following:

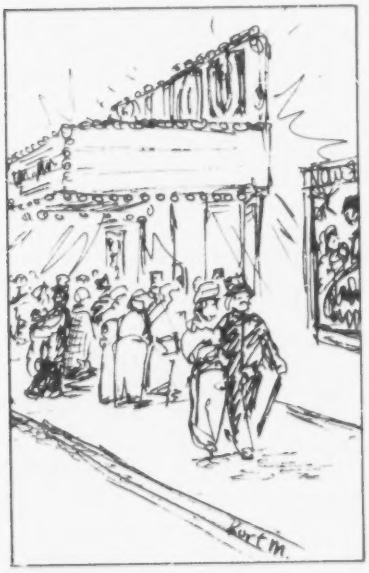
- More adequate basic training of supervisors to help them deal with problem employees, regardless of the sex of the subordinate.

- Special training of supervisors to make them aware of their differing attitudes and behavior toward subordinates according to their sex.

- Women's groups or other mechanisms that provide adequate assurances of confidentiality to provide an

informal forum for interchange and support among females in the work force experiencing both personal and job problems.

The effectiveness of these special training and support groups targeted to reaching alcoholic women was to be assessed in phase III. A final report covering the entire project is expected to be completed soon.



New Film Trains Supervisors

The Troubled Employee, produced by the Dartnell Company, is a training film to help supervisors identify and refer employees experiencing problems that adversely affect job performance. This film presents a five-step process for dealing with the troubled employee: (1) recognition of the job problem, (2) documentation of problems, (3) action taken by supervisor to intervene in the job situation, (4) referral to the appropriate in-house resource (EAP) for assessment, and (5) reintegration of the employee into the work situation. A list of practical do's and don'ts is provided to assist the supervisor. For information on rental or purchase, contact Mickey Marnstein, Dartnell, 4660 Ravenswood Ave., Chicago, IL 60640.

EAPs and Health Promotion Programs: Mutually Supportive

Health promotions programs are being established in industry nationwide as a means of educating workers toward a healthier lifestyle and greater productivity. Programs promote exercise, good diet, and smoking cessation—all intended to reduce the risks of workers becoming ill, and at the same time, to improve the general quality of his or her life. Health promotions programs differ in approach from traditional employee assistance programs, which are geared toward intervention and treatment of problems once these problems have begun to interfere with a worker's job performance, health, or important family or social role commitments.

The work of employee assistance programs and health promotions efforts can be viewed as essentially separate and independent. However, with the current interest in stress management and other alcohol-related health issues, the long-term health benefits of health promotions efforts may be establishing themselves as a permanent part of employee services in many businesses and industries.

Among employee assistance programs there exists a rich and varied range of options for addressing problems and offering service. For example, some programs offer alcohol services exclusively, others offer mental health or family counseling exclusively, and yet others provide counseling services for a broad range of employee problems, including alcoholism, drug abuse, mental health, family, marital, legal, and financial.

Other EAPs do not concentrate on counseling at all, but rather focus assistance in the areas of identification and referral or in identification, assessment, and referral. Some comprehensive programs offer both short- and long-term counseling as well as identification, assessment, and referral services.

And, finally, some EAPs offer extensive information and education campaigns to their entire working population. Although these alcohol awareness activities are generally only a part of EAPs that are well established, alcohol abuse education and prevention activities are important areas for future EAP growth.

While EAPs and health promotions programs may operate successfully as separate entities on their own merit, opportunities for mutual support and cooperation exist in such important areas as employee education and behavioral and medical problem prevention.

—Jim O'Hair

ReadersExchange

One Won't Hurt: Anatomy of a Common Relapse

George M. DuWors, LCSW

"I just thought one drink wouldn't hurt anything."

"I thought I could handle it now."

"This time was going to be different."

"I only wanted to drink socially."

How often do we who work in alcoholism treatment hear variations on these themes: the harmlessness of a drink or two, the belief in self-control? When thought becomes action, more than one drink usually follows. The story that begins with "I'll just have one" invariably ends with full-blown alcoholic relapse. If so many alcoholics share these ideas, and the results are so similar, maybe this pattern lies close to the heart of their shared problem. At the very least, we might find ways to prevent such relapses by examining the process to see how it works.

First of all, we might ask how one person can keep repeating the same apparent mistake, planning to drink "just one" and proceeding to drink many more. Some do this even after saying, "I am an alcoholic," and after completing a treatment program. All programs that treat alcoholism as a disease teach the patient that one drink will trigger the addictive cycle. Apparently, the drinker does not believe this at the crucial moment when he or she asserts "one won't hurt," nor does the drinker listen to experience, which has been trying to communicate for years that "one hurts *you*."

We seem to be face-to-face with the question of how people come to believe what they believe. The mind always has two forces drawing its attention, like the two poles of a magnet. One force is the facts, specific and concrete, or vague and unknown: Reality with a capital R. The other force, the heart's desire or Wishes, pulls the mind toward any belief that confirms that what we want to be so, is so. When the mind ignores, denies, or forgets facts and believes what it wants to be true, what is going on is "wishful thinking." When the wishful thinker acts on the wishful belief in the real

Author's Note: This article is based on a lecture that has been well received by alcoholic patients. I have tried to write it in the same spirit as it was delivered—communicating with metaphor and everyday language rather than hiding behind jargon. My goal, then, is not just to disseminate information but to have an effect.

world, there follows a "head-on" collision with Reality, and the head never wins.

It would appear that the alcoholic is drawn to believe that "one won't hurt" by the power of his or her own wishful thinking. The mind believes and the person drinks, stepping off the cloud of Wishes to crash once more on the hard ground of Reality. In fact, the only thing "self-fulfilling" about the wishful "prophecy" is that it gets a drink into the drinker with a minimum of guilt, anxiety, or resistance. After all, the wishful thinker believes, What's the big deal about one little drink?

Before trying to prevent the wishful take-off and inevitable disastrous crash, we need to know what the "wish" is. What is it that the addictive drinker wants so badly that he or she has to fly in the face of the facts one more time?

It does not take a Freud to recognize that a person who still believes "one won't hurt" wishes to drink, to live once more in the world alcohol creates and in which all wishes seem to come true. It may not be quite so obvious that the person wishes to drink again in the old manner, but if we want objective evidence, we need only look at what actually happens. We have the consistent reports of minds who used to play that game: "As many times as I said I was only going to have one, there was never one time when that was all I really wanted. Afterall, what good is one drink?"

The thought that "one won't hurt" ignores or conceals two facts. The immediate reality is that a person who wants to drink is telling himself that one swallow will do. Lurking behind that seductive thought lies a ravenous, insatiable desire. The mind shows an incredible talent for hiding from the most powerful and frightening urges of the body, but unfortunately for alcoholics, when the mind looks the other way, it gives free rein to the desire—a desire that powerfully demands enough drinks to do some damage. And "social drinking" is not about to appease it. The second concealed fact, which inevitably follows from the desire, is the loss of control that is almost synonyous with alcoholism. The long list of failures at stopping with "just one" has been accumulating for years, and whether or not the person eventually faces it, loss of control is a fact of life by the time "one won't hurt" becomes an invitation to relapse.

As explored so far, this whole wishful thinking process may seem strangely complicated and roundabout. If you want to drink badly enough to risk hurting yourself or others, why not just say so? Or, if the desire to drink is so strong that you feel helpless to fight it, why not just admit defeat and give in? There are two reasons, both of which point up the roundabout nature of wishful thinking.

First, your picture of yourself probably does not include an insane desire for alcohol. If you see yourself as Dr. Jekyll, a pillar of the community, it may be too distressing to look in the mirror and see the wretched Mr. Hyde.

Second, recognizing your raw desire for alcohol would also bring you face-to-face with the power of your disease. No one can be blamed for trying to avoid this reality.

George DuWors, LCSW, is a clinical social worker at the Brentwood VA Medical Center, Los Angeles, California.

What does this description of wishful thinking tell us about how we might help the alcoholic in danger of relapsing? We can start by looking at how much of this kind of thinking our new patient has already done. Specifically, what was the sober mind saying to itself the last time the person started drinking? Most patients have tried quitting on their own and many have been in treatment before. The question is not *why* you started drinking again, but *what* was going on in your sober, alcohol-free mind at the moment you picked up the first drink.

Whether working with individuals or groups, inpatients or outpatients, counselors would do well to encourage alcoholic clients to express their temptations out loud. Once a piece of wishful thinking has been shared with others, the "collision with reality" can occur in therapy instead of on the "outside." One way or another, we must try to help the patient face those two facts that the wish would conceal—the power of the desire right now and the inevitability of losing control.

Unfortunately, if the desire for alcohol is too strong, and the desire for sobriety and survival are unable to assert themselves in time, we may have to watch Wish collide with Reality one more time. False starts and real suffering often seem to be necessary before acceptance of alcoholism goes more than skin deep. We have not yet found a way to completely eliminate this struggle, as much as we might wish to do so. There may be times when we are tempted to believe that we have discovered the answer, only to find that the ground is still just as hard for us as it is for our patients.

Letters

To The Editor:

When I became a member of the Editorial Advisory Board of *Alcohol Health and Research World* (AH& RW), I was told that all articles concerning gay/lesbian issues would be sent to me for editorial comment because that is my area of expertise and interest. What I now discover is that this policy covers only matters of commission, not those of omission.

While reading the current issue on "Self-Help Groups" in *AH&RW* (Summer 1982), I became increasingly distressed by the omission of *any* mention of the self-help groups devoted to helping both gay/lesbian alcoholics and alcoholism professionals. Thus while the issue discusses Women for Sobriety groups, it does not mention the gay/lesbian groups of AA; while the issue lists such professional self-help organizations as the Alcohol and Drug Problems Association of North America (ADPA) and the National Council on Alcoholism (NCA), it does not mention the National Association of Gay Alcoholism Professionals (NAGAP).

A whole article is devoted to "Alcoholics in the Helping Professions: Helping One Another." Yet there is no mention made of the major professional self-help group for gay/lesbian alcoholism professionals, NAGAP. And while it is true that not all NAGAP's members are alcoholics, the group *is* designed to provide support for alcoholism professionals who are gay or lesbian and therefore must contend with the stress of pervasive oppression. This support is given nationwide via regional chapters in the Midwest, California, New York, Philadelphia, and Virginia; via communication to and from the national office; and via a quarterly newsletter. This support is provided to all NAGAP's members, who include nurses, doctors, lawyers, social workers, counselors, clergy, and AA and Al-Anon members.

As a National Coordinator of NAGAP and as a member of the Editorial Advisory Board of *Alcohol Health and Research World*, I am deeply distressed by these omissions. Since gays and lesbians are an "invisible" minority, extra vigilance is required to ensure that they will receive the attention and care they need. Therefore, I hope that in the future we can work together more closely to ensure that your reporting includes this invisible minority.

Dana G. Finnegan, Ph.D., CAC
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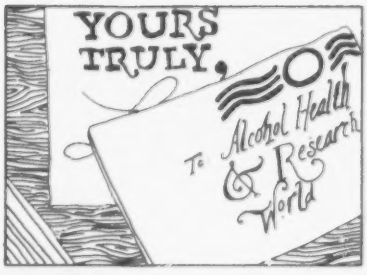

To the Editor:

The summer issue on "Self Help Groups" was exciting to read and I salute your comprehensive coverage. As an addiction counselor in private practice I find that the therapeutic process of recovery is enhanced when clients and families are committed to AA and Al-Anon programs.

For the past 2 years I have had the pleasure of serving as chairperson of Self Help/Support Groups for the Dade County Mental Health Association. Not only are the support groups meeting the needs of target populations in the community but also lay persons are being trained as leaders and professional leaders are being trained as advisors to the groups.

The caring, sharing, and support that is experienced in these groups truly demonstrates the People Helping People Network.

Patricia Berman, R.N., M.S.
Alcohol Specialist
Mental Health Counseling and
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BookReviews

STEERING CLEAR: Helping Your Child Through the High-Risk Drug Years, by Dorothy Cretcher, Dayton, Ohio: Publications for Parents, 1982, ($4.95; 112 pp.).

The lead jacket endorsement by actress Joanne Woodward for Dorothy Cretcher's *STEERING CLEAR* says that this new work contains solid information about drugs and their widespread use, and offers to parents some approaches on avoiding and coping with the problem. The book does indeed cover these topics, and more. In 105 pages, plus an appendix, the author includes mention of just about everything that can be related to the subject of teen drug use: sociocultural history; research; who uses or abuses and why; chemical definitions and drug effects; prevention efforts in home, school, and community; confronting your child's drug use or abuse; guidelines for evaluating and selecting treatment facilities; and study questions for parents who wish to use the book in a parent-group setting. The global nature of *STEERING CLEAR* is to be commended; at the same time, this comprehensive quality sometimes gets in the way, causing the author to drift away from the stated purpose of the book.

In the foreword, Sidney Cohen, M.D., writes, "The underlying theme is that a skillful attempt to reweave the torn fabric of parent/child misunderstandings and to redirect dysfunctional behaviors into healthier patterns must take place." Cretcher closes chapter 2 with the appeal that ". . . the challenge to parents is to prepare children to handle themselves even when they're surrounded by drug use . . . ." and concludes in a later chapter, ". . . our first order of business must be to strengthen our children's defenses. . . ."

I kept waiting to read her ideas on how to do this reweaving and redirecting. Just how can parents stengthen their children's defenses? It was not until the last two chapters that the author fully turned her attention to answering this important question.

The first two chapters provide suitable background history for the 1982 drug scene. Chapter 3 presents data from research studies and surveys, with general credit given to the Institute for Social Research at the University of Michigan and to the National Institute on Drug Abuse. Readers who have been trained in research may be dismayed at the lack of footnotes or specific bibliography, because Cretcher announces some very interesting findings. By the end of this chapter, entitled "The Who, What and Why of Adolescent Drug Use," the author begins to interject some of her own well-formulated thoughts and observations. For example, the answer given frequently by teen drug users in response to the adult question "Why do you use drugs?" is "Because it makes me feel good." Cretcher responds that "young people with strong family relationships feel good in the first place." Her observations unfortunately are sprinkled too sparingly in the middle third of the book.

Chapters 4, 5, and 6 present easily read, informative technical articles on various drugs. The author wisely begins with alcohol and tobacco and stresses repeatedly that alcohol is the most widely used drug of teenagers.

Chapter 7 on "Prevention: What You Can Do" begins by spelling out what skills children need in order to negotiate in the world and offers suggestions on how parents can help their children acquire these skills. I would have preferred to see this chapter lengthened considerably. Just when Cretcher is getting into her element—suggesting to parents, "Don't insist nothing is wrong as you bang the silverware. Your children won't believe you. . . ."—the focus shifts to parents in relation to school programs and the community at large.

A too-brief chapter 8 addresses the subject of dealing with the drug use of your child and confront the range of

Price Increase for AH&RW Subscriptions.

Effective with the Fall 1982 issue of *Alcohol Health and Research World*, the Government Printing Office announced an increase in the yearly subscription rate. This quarterly magazine now costs subscribers $11 per year ($13.75 to foreign addresses). Subscription requests should be sent to Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. Check, money order, or charge card authorization (name, card number, and expiration date) for VISA or Mastercard must accompany the subscription request.

teen drug use from experiment to addiction. The section on parental confrontation of experimental drug use is excellent, truly the highlight of the book. Advice to parents on how to handle more severe drug involvement is less impressive. For example, under the subheading "Dealing with Regular or Frequent Drug Use," the author suggests family problem solving as one remedy. The specific technique described—with communication and listening skills listed as a requirement—appears to me to be highly unlikely to succeed without the presence of a trained counselor or family therapist. By the time a teenager has progressed to regular or frequent drug use, self-esteem and empathy—the crucial underpinnings of successful communication—are apt to be quite impaired in a family with a drug-dependent member.

STEERING CLEAR is written for parents who are concerned about their children's potential to use or abuse drugs. The book ends with a list of study questions that seem designed for use by groups of parents. Getting parents to meet together to talk about this difficult modern problem is not easy, and often the parents who need to discuss kids and drugs the most are the very ones who adopt an ostrich approach until it is almost too late. Be that as it may, the group discussion questions included here are specific enough to be useful and general enough to stimulate input from even defensive and anxious parents.

Tarpley M. Richards, LCSW
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Alcohol Programs for Higher Education, by James C. Dean and William A. Bryan (eds.), Carbondale, IL: ACPA Media, Southern Illinois Press, 1982 ($11; 144 pp).

This book makes the point that "alcohol is the most widely abused drug in American colleges and universities." Moreover, the authors point out that among young adults in general, regular drinking is more common than regular use of any other substance including cigarettes and coffee. However, *Alcohol Programs for Higher Education* is not a book about prevalence of alcohol use and abuse in colleges and universities; instead it is an attempt to offer a "plan for a systematic and effective program to deal with alcohol-related problems on the campus."

The book consists of 10 chapters by several writers. The first three chapters by James C. Dean explain why there is a need for a systemic, multipurpose alcohol program on the college campus. Dean emphasizes that the campus must be treated as a community, having a unique personality and reality, but made up of basic subgroups of students, faculty, and staff. Dean suggests that an understanding of the reality on both the whole campus and the subgroups is crucial to developing an effective alcohol program.

In the second chapter, Dean introduces an "Alcohol Programs Continuum Based on Behavioral Observations." The continuum, which covers from abstention to addiction, is proposed as an assessment tool. Dean writes that "the overwhelming number of persons who experience alcohol problems are not abstainers or classic alcoholics, they are the social drinkers and those who experience problems directly connected to their consumption of the substance."

Dean proposes a systems approach to the prevention of alcohol problems based on the assumption that a series of planned, integrated problem interventions will alter individual behavior within a group. He further asserts that alcohol use by students, faculty, and staff cannot be understood as isolated behavior. Therefore, Dean suggests that in combination with the problem prevention continuum a systemic approach must be based on a conceptual foundation that focuses on the entire campus system as well as on its subsystems.

Chapter four, written by William A. Bryan, presents an organizational option for administering a campus alcohol program. He stresses that institutional commitment from the president's office on down is necessary for the effective administration of an alcohol program, and concludes that "alcohol policies and regulations have done little in the past to solve the problems created by the abuse of alcohol." He challenges higher education administrators to review their policies and regulations and to put them in step with the basic philosophies of an educational community.

Chapters five through nine discuss specific prevention strategies including the use of an interdisciplinary program offering alcohol-related courses in the university curriculum, intervention strategies in living units, the use of students as "community developers," and the implementation of an employee and faculty assistance program. Chapter six by Robert A. Schwartz offers a fairly structured how-to guide for a peer-based model of intervention in living units. Among other things,

Schwartz covers the essentials of recruitment and selection, training, and evaluation. He points out that trained peer counselors can be helpful in promoting an open and responsive climate for alcohol awareness and education in living units.

The last chapter, by Hannah E. and James C. Dean, stresses the need for evaluation of campus alcohol programming and offers a rather elaborate evaluation model. In addition to a description, the authors of this chapter offer a set of "practical questions" to be raised by prospective evaluators.

In general, the greatest contribution of this book seems to be the presentation of a realistic conceptual model that can be used in planning and developing a campus alcohol program. It is written in a clear, concise manner and organized in a logical sequence. However, with the exception of the chapter by Schwartz, the alcohol program specialist interested in specific practical how-to ideas for effective campus programs would not find a great deal of assistance in the book. For example, while a convincing rationale is offered for a systemic approach focused on faculty, staff, and students, no specific ideas are presented for overcoming the "very difficult problem" of effective programming for faculty.

I would have appreciated a greater emphasis on the crucial role students can play in an effective campus alcohol program. Students can, and probably should, be the "axis" around which other aspects systemic campus alcohol program can revolve. Students—whether they are involved as part of work-study or as volunteers or are working for academic credit—must be an integral part of promoting the basic mission of an alcohol program, which, as Bryan puts it in chapter four, is "to promote responsible decisions about the use of alcohol."

Nevertheless, this book makes an important contribution to the literature on alcohol programs in higher education. Even if its main achievement is to alert the reader to the existence of alcohol problems in higher education and to the need for a comprehensive, realistic effort by the institutions to address them, that is a major step forward in an area of higher education that for too long has suffered from a general attitude of benign neglect.

The administrator seriously concerned with alcohol problems on campus will find the book to be a motivator in pursuing further research and investigation into successful campus alcohol programs.

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